Electronically Delivered

April 15, 2025

Licensee
Moose Lake Village Assisted Living
4560 County Highway 61
Moose Lake, MN 55767

RE: Project Number(s) SL20329016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 18, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20329016-0 On March 17, 2025, through March 18, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 12 resident(s); 12 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 18, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 17,	0 630		

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0 630	Continued From page 4 2025, at 9:59 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were familiar with the assisted living requirements. R2 R2's diagnoses included depressive disorder, type two diabetes, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body). R2's Service Plan dated January 28, 2025, indicated R2 received assistance with dressing, grooming, bathing, blood glucose (sugar) monitoring, medication management, housekeeping and laundry. On March 18, 2025, at 10:37 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R2's scheduled medications. R3 R3's diagnoses included hearing loss, hypertension (high blood pressure), atrial fibrillation (irregular heartbeat), and Meniere's disease (condition of the ear that causes dizziness). R3's Service Plan dated August 6, 2024, indicated R3 received assistance with medication management, housekeeping and laundry. R2 and R3's Individual Abuse Prevention Plans (IAPP) dated January 23, 2025, and February 6, 2025, included assessment of the person's susceptibility to abuse by another individual including vulnerable adults, the person's risk of abusing other vulnerable adults; however, respectively, lacked an individual assessment of the resident's risk of self-abuse.	0 630		

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0 630	Continued From page 5 On March 18, 2025, at 1:14 p.m., LALD/CNS-A reviewed R2 and R3's IAPP assessments and stated R2 and R3's assessments did not directly address a resident's susceptibility of self-abuse. LALD/CNS-A stated they would look into expanding the licensee's IAPP assessment to address the review of self-abuse. The licensee's Individual Abuse Prevention Plan-AL MN policy dated December 13, 2024, indicated an individual abuse prevention plan would be developed for each assisted living resident to include: -individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults; -the resident's risk of abusing other vulnerable adults -specific measures to minimize the risk of abuse to that person and other vulnerable adults; and -measure to minimize the risk of self-abuse, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 775		

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0 775	Continued From page 6 failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 17, 2025, at 11:00 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the facility tour, the surveyor observed the following: - Door closers had been disconnected on labeled fire doors for resident rooms throughout the facility. These fire doors did not self-close and positively latch. During the tour interview, DM-D stated the door closers were this way when they started working here and did not know why the closers had been disconnected. All components of a fire door assembly must be maintained in proper working order. - The smoke alarm in occupied resident room 8 did not provide an audible alarm when tested by DM-D. During the tour interview, DM-D verified the smoke alarm observation. Smoke alarms must be maintained in operable condition. - Burnt cigarettes had been disposed of on the ground and in a bucket at the front of the building. Burnt cigarettes were disposed of in a plastic container on the patio located out the side door. During the tour interview, DM-D verified the smoking material disposal observations. During	0 775		

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0 775	Continued From page 7 an interview on March 17, 2025, at approximately 1:30 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the front smoking area was used by employees and the designated area for residents was the side patio. Improper disposal of smoking materials creates a fire hazard. - The emergency light labeled EML13 did not work when tested by DM-D. During the tour interview, DM-D stated they were already aware this emergency light did not work and were waiting for the repair item to arrive in the mail. All emergency lights must be maintained in operable condition to ensure sufficient illumination will be provided in the corridor. - Extension cords were used to supply power in occupied resident rooms 2 and 8, creating a fire hazard. During the tour interview, DM-D verified the extension cord observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 800		

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0 800	Continued From page 8 failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 17, 2025, at 11:00 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the facility tour, the surveyor observed areas of the sidewalk were chipped at the front and side of the building, creating a trip/fall hazard. During the tour interview, DM-D verified the above listed observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire	0 810		

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0 810	Continued From page 9 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 810		

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0 810	Continued From page 10 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 17, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN - Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP with procedures specific to the assisted living facility and the building occupants. The FSEP with a revised date of July 1, 2024, was a comprehensive fire plan for skilled nursing and assisted living. The procedures and actions were combined into one plan for both buidlings. During an interview on March 17, 2025, at 1:45 p.m., LALD/CNS-A verified a FSEP had not been developed for the assisted living building. - All parts of the fire safety and evacuation plan (FSEP) were not located in a central location for all staff accessibility. LALD/CNS-A stated during an interview on March 17, 2025, at 1:45 p.m., that the specific procedures for individualized unique needs of residents for evacuation during a fire or similar emergency were maintained electronically and accessible on the computer. These procedures were not included in the binder where the other parts of the FSEP were located. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year evident by a review of records lacking the required frequency.	0 810		

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0 810	Continued From page 11 Documentation for an annual FSEP employee training completed on February 29, 2024, was provided. No additional training records were provided to support employee FSEP training had been completed in the past 12 months. During an interview on March 17, 2025, at 1:45 p.m., LALD/CNS-A stated additional FSEP training had been completed but not recorded and verified the records lacked the required documentation. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill reports. Four fire drills were recorded in 2024. These drills were completed in July, October, and December. Evacuation drill records were not provided for 2025. During an interview on March 17, 2025, at 1:45 p.m., LALD/CNS-A stated they were not able to locate any additional evacuation drill records and verified the frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

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01760	Continued From page 12 completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for one of three residents (R1) observed during medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 17, 2025, at 9:59 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to residents at the facility. R1's diagnosis included type II diabetes. R1's service plan dated January 1, 2025, indicated R1 received daily medication administration. R1's prescriber orders dated February 27, 2025, included an order for Tresiba (long-acting) insulin	01760		

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	20329	A. BUILDING: _____ B. WING _____	03/18/2025

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01760	Continued From page 13 36 units daily and Novolog (long-acting) insulin four units three times a day, and call the RN if blood sugar was less than 120 milligrams/deciliter (mg/dl) and hold insulin. See prn (as needed) order for blood sugars over 150 mg/dl. Novolog prn orders directed to administer the following Novolog per blood sugar levels as follows: 150-199 mg/dl administer one unit of Novolog; 200-249 mg/dl administer two units of Novolog; 250-299 mg/dl administer three units of Novolog; 300-350 mg/dl administer four units of Novolog; 351-399 mg/dl administer five units of Novolog; and 400-499 mg/dl administer six units of Novolog. On March 18, 2025, at 7:13 a.m., the surveyor observed unlicensed personnel (ULP)-E monitor R1's blood glucose with a reading of 157 mg/dl. ULP-E stated R1's blood glucose was monitored before R1 received his Novolog insulin because R1 received addition units of Novolog based on R1's blood glucose reading. ULP-E primed R1's Tresiba insulin then dialed 36 units of insulin and injected into R1's right lower abdomen. ULP-E proceeded and primed R1's Novolog insulin then dialed four units of Novolog insulin and injected the medication into R1's left lower abdomen. The surveyor requested to view R1's prn Novolog insulin directions in R1's electronic medical administration record (EMAR) and ULP-E stated the instructions were written on a piece of paper inside of R1's cupboard in his room. ULP-E stated generally R1 did not get up until late morning or came to breakfast so R1's blood glucose and insulin were normally administered in R1's room. ULP-E confirmed R1 received a total of four units of Novolog insulin. On March 18, 2025, at 9:00 a.m., the surveyor observed R1's prn Novolog insulin instructions on	01760		

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	20329	A. BUILDING: _____ B. WING _____	03/18/2025

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MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

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01760	Continued From page 14 a piece of paper in R1's cupboard and instructed to administer one unit of prn Novolog insulin for a blood glucose range of 150-199 mg/dl. On March 18, 2025, at 11:20 a.m., the surveyor reviewed R1's EMAR with LALD/CNS-A. LALD/CNS-A stated R1 was to receive four units of Novolog insulin three times a day and additional Novolog insulin was based on R1's blood glucose reading. LALD/CNS-A stated R1's documented blood glucose at 7:27 a.m., that morning was 157 mg/dl and R1 should have received one extra unit of Novolog insulin for a total of five units. LALD/CNS-A stated R1's medication sheet did not indicate R1's received the extra dose of Novolog insulin and only received four units instead of five units. LALD/CNS-A stated R1's Novolog insulin instructions in R1's EMAR could be written more clearly to ensure the prn insulin was in addition to R1's regular scheduled dose. The licensee's Insulin Pen policy dated November 4, 2024, indicated to check the medication label with the EMAR (confirm right resident, medications, dose, dosage form, frequency and route). If the resident had frequent insulin order changes, check with the current physician orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890		

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01890	Continued From page 15 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened and expiration dates for one of two residents (R1) whose medications were stored by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 17, 2025, at 9:59 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. On March 17, 2025, at 1:59 p.m., the surveyor reviewed the medication cart with unlicensed personnel (ULP)-C and observed the following: R1's opened Tresiba (long-acting) and Novolog (rapid-acting) insulin pens lacked the date the insulins had been opened and when the insulins would expire.	01890		

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01890	Continued From page 16 On March 17, 2025, at 2:03 p.m., ULP-C stated they normally wrote the date on the insulin pens when opened and stated there was no date written on R1's insulin pens indicating the date the insulins had been opened or would expire. On March 18, 2025, at 1:14 p.m., registered nurse (RN)-B stated staff were trained to write the date on the medication when opened. The manufacturer's instructions for Tresiba insulin dated July 2022, instructed to throw away 56 days if it is refrigerated or kept at room temperature even if it still had insulin left in it and the expiration date has not passed. The manufacturer's instructions for Novolog insulin pen dated November 2021, instructed to throw away 28 days after use, even if it still had insulin left in it. The licensee's Insulin Pen policy dated March 25, 2024, indicated if a new insulin pen is obtained from the refrigerator, bring to room temperature before administration and document "date open" or "use by date" on the pen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	03/18/2025

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02320	Continued From page 17 sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel (ULP)-C) observed administering medications. This practice resulted in a level two violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on March 17, 2025, at 9:59 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included depressive disorder, type two diabetes, hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body). R2's Service Plan dated January 28, 2025, indicated R2 received assistance with dressing, grooming, bathing, blood glucose monitoring, medication management, housekeeping and	02320		

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02320	Continued From page 18 laundry. R2's hospice orders dated March 14, 2025, included hydromorphone 2 milligrams (mg) 0.5 tablet every six hours for pain. ULP-C's employee record contained a competency evaluation completed by registered nurse on medication administration dated November 5, 2020. On March 17, 2025, at 12:46 p.m., the surveyor observed R2's hospice nurse from an outside provider, inform ULP-C R2 was requesting hydromorphone (a pain medication). ULP-C prepared R2's hydromorphone and handed the medication to the hospice nurse to administer to R2. The hospice nurse proceed and walked to R2's room and administered R2's hydromorphone while ULP-C remained in the office. R2's March 2025, Medication Sheet included ULP-C's initials indicating ULP-C prepared R2's hydromorphone and R2 hydromorphone 2 mg was administered on March 17, at 12:57 p.m. On March 18, 2025, at 1:16 p.m., LALD/CNS-A stated they educated ULP-C on the licensee's medication administration procedure and ULP-C should not have prepared R2's medication and allowed R2's outside provider administer the medication. The licensee's Medication Administration by Unlicensed Personnel policy date November 4, 2024, indicated the procedure for medication administration included the following: -preparing the medication for the resident; -administration of the medication to the resident; and	02320		

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02320	Continued From page 19 -documentation of the signature of the person who medication administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/18/25*
Time: 10:30:00
Report: 1027251039

Food and Beverage Establishment Inspection Report

Location:
Moose Lake Village Assisted Li
4560 County Highway 61
Moose Lake, MN55767
Carlton County, 09

Establishment Info:
ID #: 0038607
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2183519415
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

AT TIME OF INSPECTION THE THERMOMETER USED FOR MEASURING DISH MACHINE HOT WATER TEMPERATURE WAS NOT WORKING. REPLACE BATTERIES IN THERMOMETER OR REPLACE THERMOMETER.

Comply By: 04/01/25

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

AT TIME OF INSPECTION THERE WERE NO TEST STRIPS FOR MEASURING QUATERNARY AMMONIA SANITIZER IN RECEIVING KITCHEN.

Comply By: 04/01/25

Surface and Equipment Sanitizers

Hot Water: = at 173 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANITIZER WIPE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *03/18/25*
Time: 10:30:00
Report: 1027251039
Moose Lake Village Assisted Li

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	2	0

KITCHEN IS ONLY USED AS A RECEIVING KITCHEN. ALL FOOD IS PREPARED IN HOSPITAL KITCHEN THAT IS IN ADJACENT BUILDING AND INSPECTED BY ANOTHER UNIT.

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 1027251039 of 03/18/25.

Certified Food Protection Manager: JAY PITTMAN

Certification Number: FM81832 Expires: 08/20/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
THERESA HEAVIRLAND
MANAGER

Signed: Ian Harrison
Ian H

651-201-4500
health.foodlodging@state.mn.us

Report #: 1027251039

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	/ /
No. of Repeat RF/PHI Categories Out	0	Time In	
Legal Authority MN Rules Chapter 4626		Time Out	

Address	City/State	Zip Code	Telephone
	,		

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	IN	OUT	N/A	(N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	(N/A)	N/O	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	(N/A)	N/O	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT (N/A) N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/18/25

Inspector (Signature) Dan Harrison