Electronically Delivered
February 16, 2022

Administrator
Americare Lodges Inc
6870 Schultz Drive Northeast
Remer, MN 56672

RE: Project Number(s) SL30705015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 28, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

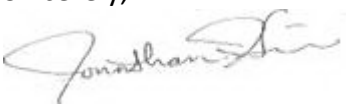
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30705	A. BUILDING: _____ B. WING _____	01/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE LODGES INC	6870 SCHULTZ DRIVE NE REMER, MN 56672

(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 Initial comments ******ATTENTION****** 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: SL30705015 On, January 26, 2022, through January 28, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were eight (8) residents receiving services under the provider's Assisted Living license.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facility providers. 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 surveyors' 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.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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) 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 27, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, as well as the contact information for the Mental Health and Development Disabilities. This had the potential to affect all eight (8) 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, 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).	0 550		

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0 550	Continued From page 3 The findings include: The licensee lacked a posting to include all the required content about the facility's grievance procedure to include the email contact information for the individuals who were responsible for handling grievances, and the contact information for the Mental Health and Development Disabilities. During the facility tour on January 26, 2022, at approximately 10:38 a.m. with licensed practical nurse (LPN)-B, the main entrance lacked the required posting of the grievance procedure and contact information for the Mental Health and Development Disabilities. On January 26, 2022, at approximately 1:45 p.m. licensed assisted living director (LALD)-A confirmed the required content noted above was not posted as required. The licensee's Complaint/Grievance Posting policy dated September 1, 2021, indicated the licensee will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for individual(s) who are responsible for handling resident complaint/grievances. The policy further indicated the posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 550		

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0 640	Continued From page 4	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas to include: posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all eight (8) 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, 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:	0 640		

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0 640	Continued From page 5 The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. During a facility tour on January 26, 2022, at approximately 10:38 a.m. with licensed practical nurse (LPN)-B, the common areas did not have the required postings for 911 emergency number. On January 26, 2022, at approximately 1:45 p.m. Licensed Assisted Living Director (LALD)-A confirmed the office and kitchen portable telephones were used by the residents, and did not have the required postings for 911 emergency. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated September 1, 2021, directed posting the 911 emergency number in common areas and near telephones provided by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 6 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all eight (8) 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, 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:	0 680		

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0 680	Continued From page 7 During the entrance conference on January 26, 2022, at approximately 10:06 a.m., a request was made to view the licensee's emergency preparedness plan, which was provided and later reviewed by the surveyor. During the initial facility tour on January 26, 2022, at approximately 10:38 a.m. with licensed practical nurse (LPN)-B, the main entrance and the two common areas lacked signage posted or information regarding the licensee's emergency preparedness plan in any of the common areas, main entrance, or elsewhere in the facility. The licensee's emergency preparedness plan included emergency plans for a fire, severe weather procedure, and a procedure for tornado. The licensee's plan lacked the following content and/or policies and procedures to address: - a comprehensive program to include man-made disasters, facility based (power, water etc.), infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - the facilities role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - a tracking system used to document locations of residents and staff; - an evacuation plan; - how the facility would provide a means to shelter in place for residents and volunteers; - the medical record documentation system the facility has developed to preserve resident information security and availability of records;	0 680		

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0 680	Continued From page 8 - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families On January 28, 2022, at approximately 12:17 p.m. Licensed Assisted Living Director (LALD)-A confirmed the emergency plan was kept in the office, and verified the required content noted above was not posted as required. LALD-A confirmed she was not very familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). LALD-A verified she had not fully developed and implemented the facility's emergency preparedness plan/program. The licensee's Disaster Planning and Emergency policy dated September 1, 2021, indicated the licensee would have in place a general emergency preparedness plan, that would be in alignment with the facility's requirement to also	0 680		

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0 680	Continued From page 9 comply with CMS Appendix Z. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated September 1, 2021, indicated the licensee's emergency preparedness plan would include all required elements of Appendix Z. The plan would be in writing and reviewed annually. The plan would be based on the licensee's assisted living and community-based risk assessments, utilizing and all hazards approach. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;	0 730		

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0 730	Continued From page 10 (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a resident record included a discharge summary for one of one discharged resident (R3) with record reviewed. 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	0 730		

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0 730	Continued From page 11 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: R3's diagnoses included dementia, delirium, post hip fracture and repair, and mood disorder. R3 started to receive assisted living services on August 1, 2021, and was discharged on December 16, 2021. R3's Service Plan dated September 26, 2021, indicated R3 received services, which included assistance with activities of daily living, laundry, housekeeping, and medication management. R3's record lacked evidence a discharge summary was completed. On January 26, 2022, at approximately 1:45 p.m. Licensed Assisted Living Director (LALD)-A confirmed a discharge summary had not been completed for R3. The licensee's Discharge Summary policy dated January 26, 2022, indicated upon discharge nursing staff will conduct a Discharge Summary to include: -the resident name. -the date service was started. -date that a written notice was given to the resident if applicable. -date that a written notice was given to the Administrator if applicable. -reason for termination of service. -what type of servers were provided to the resident. -the summary of care provided (care, treatment,	0 730		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE LODGES INC	6870 SCHULTZ DRIVE NE REMER, MN 56672

(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
0 730	Continued From page 12 interventions and/or referrals). No further information provided. TIME PERIOD OF CORRECTION: Twenty-One (21 days	0 730		
0 800 SS=F	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 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 all eight (8) residents and staff. 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 January 27, 2022, between 10:00 a.m. and 10:40 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During	0 800		

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0 800	Continued From page 13 the facility tour, survey staff observed the following: 1. Two ashtrays contained cigarette butts and were observed on a table in the four-season porch that was attached to the main facility. During the facility tour interview with LALD-A, it was confirmed that the four-season porch was being used by a resident for smoking. 2. In resident room 5, an electrical outlet adjacent to the bathroom sink was missing a cover. 3. In resident room 10, the main light fixture was not provided with a cover and light bulbs were exposed. 4. During the facility tour interview with LALD-A, it was confirmed that a cover was missing from the electrical outlet in resident room 5 and that light bulbs were unprotected in resident room 10. The LALD-A stated that covers needed to be installed on both the electrical outlet and light fixture. 5. The room number for resident room 10 was not visible, decorations on the door covered the room number. During the facility tour interview with LALD-A, it was confirmed that the room number was obstructed and that room numbers should be visible. No further information was provided. 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	0 810		

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0 810	Continued From page 14 rooms; (2) employee actions to be taken in the event of a fire 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) Employees 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 employees 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 document review and interview, the licensee failed to provide the required resident training, evacuation drill frequency, and accurate plans for fire safety and evacuation. This had the potential to affect all eight (8) residents and staff. 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	0 810		

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0 810	Continued From page 15	0 810		

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 January 27, 2022, at approximately 10:45 a.m., LALD-A provided documents for review.

Documents were reviewed by survey staff on January 27, 2022, between 10:45 a.m. and 11:10 a.m.

1. No documentation on resident training for fire safety and evacuation was provided.
2. One fire drill log dated 07-28-2021 was provided. The 4.05 fire policy dated 08/01/2021 stated that fire drills were not mandatory but were to be conducted 2-3 times per year.
3. The 4.05 fire policy dated 08/01/2021 references:
   a. magnetic door holds and sprinklers, which the facility did not have;
   b. smoke compartment doors, but locations of these doors were not identified;
   c. a fire alarm system that is wired directly to the fire station, the LALD-A confirmed during the exit interview, at approximately 11:20 a.m., that the fire alarm system was not wired to the fire station;
4. The 4.05 fire policy dated 08/01/2021 does not include the identification of unique or unusual resident needs for movement or evacuation.

On January 27, 2022, between 11:15 a.m. and 11:25 a.m., during the exit interview with LALD-A, they confirmed that resident training for fire safety and evacuation was not being completed and that evacuation drill frequency was not met. LALD-A additionally confirmed that the fire policy required

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0 810	Continued From page 16 revision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written	0 920		

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0 920	Continued From page 17 assisted living contract with the required content for one of one resident (R1) with record reviewed. This had the potential to affect all eight (8) residents. 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: R1's diagnoses included hypertension (high blood pressure), diabetes, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and depression. R1's Service Plan dated March 1, 2021, indicated R1 received services, which included assistance with activities of daily living, housekeeping, and blood sugar check assistance. R1's assisted living contract signed March 1, 2021, lacked the following content: -a disclosure of the category of assisted living facility license held by the facility and, if the facility was not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. On January 26, 2022, at approximately 3:03 p.m. licensed practical nurse (LPN)-B confirmed the contract provided in the admission packet was the contract used for all residents.	0 920		

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0 920	Continued From page 18 On January 27, 2022, at approximately 8:18 a.m. unlicensed personnel (ULP)-C was observed monitoring R1's blood glucose. On January 27, 2022, at approximately 11:36 a.m. licensed assisted living director (LALD)-A confirmed the contract lacked the required content as noted above, and further stated contracts would have to updated for all residents in the facility. The licensee's policy related to Assisted Living Contract contents was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the	0 930		

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0 930	Continued From page 19 Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. This affected all eight (8) residents. 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: R1's diagnoses included hypertension (high blood pressure), diabetes, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and depression. R1's Service Plan dated March 1, 2021, indicated R1 received services, which included assistance with activities of daily living, housekeeping, and blood sugar check assistance. R1's assisted living contract signed March 1, 2021, lacked the following content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a	0 930		

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0 930	Continued From page 20 transfer may occur, and the circumstances under which resident consent was required for a transfer. On January 26, 2022, at approximately 3:03 p.m. licensed practical nurse (LPN)-B confirmed the contract provided in the admission packet was the contract used for all residents. On January 27, 2022, at approximately 8:18 a.m. unlicensed personnel (ULP)-C was observed monitoring R1's blood glucose. On January 27, 2022, at approximately 11:42 a.m. licensed assisted living director (LALD)-A confirmed the contract lacked the required content as noted above, and further stated contracts would have to be updated for all residents in the facility. The licensee's Transfer of Resident within Facility policy dated September 1, 2022, indicated when entering the assisted living contract, the facility must provide a conspicuous notice of the circumstances under which the facility may require a transfer, including any transfer that may be required if the resident would be receiving housing support. The licensee's policy related to Assisted Living Contract contents was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		

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0 950	Continued From page 21	0 950		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one resident (R1) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. This had	0 950		

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0 950	Continued From page 22 the potential to affect all 8 residents who received services at the facility. 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 clients). The findings include: R1's record did not contain a notice with the required statutory language for R1 to identify a designated representative or documentation that R1 declined to name a designated representative. R1's diagnoses included hypertension (high blood pressure), diabetes, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and depression. R1's Service Plan dated March 1, 2021, indicated R1 received services, which included assistance with activities of daily living, housekeeping, and blood sugar check assistance. On January 27, 2022, at approximately 8:18 a.m., unlicensed personnel (ULP)-C was observed monitoring R1's blood glucose. On January 26, 2022, at approximately 3:03 p.m. licensed practical nurse (LPN)-B confirmed the contract provided in the admission packet was the contract used for all residents.	0 950		

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0 950	Continued From page 23 On January 27, 2022, at approximately 11:36 a.m., licensed assisted living director (LALD)-A confirmed the contracts for the residents lacked the required verbatim notice per statute to the opportunity to identify a designated representative. Thus, all the resident records lacked the notice of identifying a designated representative with the required statutory language, or the documentation they had declined to name a designated representative. LALD-A stated the current contract would need to be updated to include the required notice for all residents receiving services from the licensee. The licensee's Designated Representative policy dated September 1, 2021, indicated before or at the time of execution of an assisted living contract, the licensee would offer residents the opportunity to identify a designated representative in writing. A signed Designated Representative form must be filled out documenting the residents' choice in designated representative, the form would be kept in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting	01640		

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01640	Continued From page 24 agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual service plan was revised to reflect the current services provided for one of one resident (R1) with record reviewed. 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: R1's diagnoses included hypertension (high blood pressure), diabetes, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and	01640		

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01640	Continued From page 25	01640		

depression.

R1's prescriber orders dated January 11, 2022, included an order for blood glucose monitoring to be completed three times a day.

R1's Service Plan dated March 1, 2021, indicated R1 received services, which included assistance with blood glucose monitoring four times a day. R1's service plan was not revised to reflect R1's decrease in blood glucose monitoring from four times a day to three times a day.

R1's Master Care Plan and Individual Medication Management Plan dated December 21, 2021, indicated R1 required blood glucose monitoring.

R1's Services Delivered record for January 11, 2022, through January 27, 2022, indicated the licensee provided blood glucose monitoring three times a day for R1.

On January 27, 2022, at approximately 8:18 a.m. ULP-C was observed monitoring R1's blood glucose.

On January 28, 2022, at approximately 11:48 a.m. licensed assisted living director (LALD)-A confirmed R1's blood glucose monitoring was decreased from four times a day to three times a day according to R1's last prescribing orders on January 11, 2022. LALD-A verified R1's signed service plan did not reflect the decrease in R1's blood glucose monitoring.

The licensee's Service Plan policy dated September 1, 2021, indicated the service planned any revisions shall include a signature or other authentication by the licensee and by the resident or, resident's representative, documenting

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01640	Continued From page 26 agreement on the services provided. Service plans shall be revised, if needed based on reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	01730		

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	30705	A. BUILDING: _____ B. WING _____	01/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICARE LODGES INC	6870 SCHULTZ DRIVE NE REMER, MN 56672

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01730	Continued From page 27	01730		

management services; and
(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for a resident to include all required content for one of one resident (R1) with record reviewed.

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 January 26, 2022, at approximately 10:06 a.m. the Licensed Assisted Living Director (LALD)-A confirmed the licensee provided medication management

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01730	Continued From page 28 services to residents at the facility. R1's diagnoses included hypertension (high blood pressure), diabetes, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and depression. R1's Service Plan dated March 1, 2021, lacked a service plan to include a written statement of the medication management services the resident received. R1's prescriber orders dated January 11, 2022, included but was not limited medications to treat diabetes, Parkinson's disease, one thyroid replacement hormone, medications to treat high blood pressure, vitamins, one iron supplement, one antidepressant, one medication to treat heartburn, one medication for sleep, and a mild pain reliever. R1's Master Care Plan dated December 21, 2021, indicated R1 received medication management services. R1's Individual Medication Management Plan dated December 21, 2021, indicated R1 required full medication management and setup. R1's Services Delivered for January 1, 2022, through January 27, 2021, indicated the licensee provided medication management services for R1 to include administration of oral, injectable and topical medications. On January 26, 2022, at approximately 11:57 a.m. unlicensed personnel (ULP)-C was observed administering R1's scheduled afternoon medications.	01730		

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01730	Continued From page 29 On January 28, 2022, at approximately 11:48 a.m. licensed assisted living director (LALD)-A confirmed R1 received medication management services which included medication storage, medication set up and medication administration. LALD-A confirmed R1's medication management plan lacked the required content. The licensee's Medication Management Individualized Plan policy dated September 1, 2021, indicated the licensee would prepare and include in the resident service plan, a written statement of the medication management services that would be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01730		
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 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.	01760		

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01760	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sliding scale insulin dosages were documented after administration, for one of one resident (R1) with record reviewed. 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 January 26, 2022, at approximately 10:06 a.m. the Licensed Assisted Living Director (LALD)-A confirmed the licensee provided medication management services to residents at the facility. R1's diagnoses included hypertension (high blood pressure), diabetes, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and depression. R1's prescriber orders dated January 11, 2022, included an order for: -Novolog (fast acting insulin) Flexpen 100 units (U) to be administered per sliding scale twice a day with meals for blood glucose readings of: -181-250 give 2 U Novolog insulin -251-300 give 3 U of Novolog insulin -301-350 give 4 U of Novolog insulin	01760		

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01760	Continued From page 31 -351-400 give 5 U of Novolog insulin R1's Master Care Plan and Individual Medication Management Plan dated December 21, 2021, indicated R1 required assistance with insulin administration. R1's Service Delivered record for January 11, 2022, through January 27, 2022, indicated the licensee provided insulin administration. R1's Medication Administration Summary record for January 11, 2022 through January 26, 2022, indicated three of 31 opportunities documented if Novolog sliding scale insulin was administered. On January 27, 2022, at approximately 8:18 a.m. ULP-C was observed monitoring R1's blood glucose. R1's blood glucose reading was 173, and no sliding scale insulin was administered. R1's record lacked documentation if Novolog sliding scale insulin was administered to R1. On January 28, 2022, at approximately 11:48 a.m. licensed assisted living director (LALD)-A confirmed R1 received medication management services to include insulin administration. On January 28, 2022, at 12:02 p.m. licensed practical nurse (LPN)-B verified R1's Medication Administration Summary lacked documentation of sliding scale dosages administered. The licensee's Medication Management-Administration and Setup policy dated September 1, 2021, indicated documentation of a medication administration would be completed immediately after the task had been performed.	01760		

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01760	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system;	01790		

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01790	Continued From page 33 (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available to include all required content. In addition, the licensee failed to provide complete documentation of the medications sent with the resident for one of one resident (R1) who had an unplanned time away. This had the	01790		

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01790	Continued From page 34 potential to affect all eight (8) residents. 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 finding include: During the entrance conference on January 26, 2022, at approximately 10:06 a.m. the Licensed Assisted Living Director (LALD)-A confirmed the licensee provided medication management services to residents at the facility. UNPLANNED TIMES AWAY POLICY AND PROCEDURE FOR ULP The licensee's Medication Management-Planned and Unplanned Time Away policy dated September 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN could delegate this task to ULP if the RN had developed written procedures for the ULP including any special instructions or procedures regarding controlled substances that were prescribed for the resident. The licensee's Unplanned Time Away Medication Set Up written procedure lacked the following required content: - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP.	01790		

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01790	Continued From page 35 DOCUMENTATION FOR UNPLANNED TIME AWAY R1's diagnoses included hypertension (high blood pressure), diabetes, Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors), and depression. R1's Services Delivered record for January 11, 2022, through January 27, 2022, indicated the licensee provided medication management services for R1. R1's Master Care Plan and Individual Medication Management Plan dated December 21, 2021, indicated R1 required medication management services. R1's prescribing orders dated January 11, 2022, included, but were not limited to medications to treat diabetes, Parkinson's disease, one iron supplement, one diuretic, one antidepressant, vitamins, and mild pain relievers. R1's Resident Note dated December 28, 2021, indicated R1 returned to the facility with medications from his stay at home. R1's Resident Note did not include the list of medications R1 returned back to the licensee. R1's record lacked documentation of the medications provided to the resident or the resident's designated representative to include who received the medications, the person who provided the medications to the resident, the name and quantity of the medications provided, if any unused medications were returned, and a review by the RN to verify that the procedure was	01790		

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01790	Continued From page 36 followed for the above noted times away from home. On January 26, 2022, at approximately 11:57 a.m., ULP-C was observed administering R1's scheduled afternoon medications. On January 28, 2022, at approximately 12:08 p.m. licensed practical nurse (LPN)-B verified R1's time away was unplanned and the medications had been provided by the ULP. LPN-B confirmed R1's record lacked the required documentation for when medications were provided to R1 for the resident's unplanned time away. In addition, LPN-B verified there was no documentation of any unused medications upon R1's return. On January 28, 2022, at approximately 1:29 LALD-A and LPN-B confirmed the licensee's Unplanned Time Away Medication Set Up written procedure lacked the required content as noted above. The licensee's Medication Management-Planned and Unplanned Time Away policy dated September 1, 2021, the unplanned time away process must be properly documented in the medication administration record (MAR), and the resident record including documenting the date the medications were given to the resident or the resident's representative and who received the medications, the person who gave the medications to the resident, the number of medications that were given to the resident, and other required information. The policy further indicated, the ULP must document in the resident's record any unused medications that were returned to the provider, including the name of each medication and the doses of each	01790		

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01790	Continued From page 37 returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all eight current clients, staff, and visitors. This practice resulted in a level one 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 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:	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 38 On January 26, 2022, at approximately 9:55 a.m. Minnesota Department of Health surveyors entered the facility. Signage posted on the main entry door of the facility indicated, "Video monitoring in progress. You may not see Arlo [security camera system] but Arlo sees you". On January 26, 2022, at approximately 12:40 p.m. licensed practical nurse (LPN)-B confirmed there were video cameras in common areas of the facility. On January 26, 2021, at approximately 1:45 p.m. the licensed assisted living director (LALD)-A stated they had cameras throughout the facility in common areas. LALD-A confirmed the licensee lacked signage with the required statutory language posted regarding the use of electronic monitoring. The licensee's Electronic Monitoring policy dated September 1, 2014, indicated signs would be installed at each facility entrance assessable to visitors that state, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55165-0975
651-201-4500

Type: Full
Date: *01/27/22*
Time: 11:35:24
Report: 8046221007

Food and Beverage Establishment Inspection Report

Location:
Americare Lodges Inc
6870 Schultz Drive Ne
Remer, MN56672
Cass County, 11

Establishment Info:
ID #: 0039324
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185664722
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

OBSERVED DISH MACHINE NOT SET TO SANITIZE CYCLE. MACHINE WAS SWITCHED TO SANITIZE CYCLE, AND A SIGN CORRECTING WAS POSTED.

Corrected on Site

5-100 Water

5-101.11P ** Priority 1 **

MN Rule 4626.0980 Provide well caps which are in good condition and firmly attached to the well casing.

OBSERVED WELL CAP LOOSE. ESTABLISHMENT WILL TIGHTEN RETAINING LUGS.

Comply By: 01/27/22

5-100 Water

5-102.11 ** Priority 1 **

MN Rule 4626.0995 Water must be obtained from a public water system that complies with the requirements of chapters 4714, 4720, and 4725. Water acquired from a nonpublic water system must meet the drinking water quality standards for noncommunity transient water systems.

PROVIDE ANNUAL WATER TESTS FOR COLIFORM AND NITRATE. TESTS MUST BE DONE BY AN ACCREDITED LAB.

Comply By: 01/27/22

Type: Full
Date: *01/27/22*
Time: 11:35:24
Report: 8046221007
Americare Lodges Inc

Food and Beverage Establishment Inspection Report

2-300 Personal Cleanliness

2-301.15 ** Priority 2 **

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.

OBSERVED BOTH BASINS OF SINK UNUSABLE FOR HANDWASHING DURING MEAL SERVICE. ESTABLISHMENT WILL PROVIDE ONE BASIN FOR HANDWASHING DURING FOOD SERVICE.

Comply By: 01/27/22

Food and Equipment Temperatures

Process/Item: Cooling
Temperature: 51 Degrees Fahrenheit - Location: Breakfast leftovers at 1.5hr
Violation Issued: No

Process/Item: Cooking
Temperature: 208 Degrees Fahrenheit - Location: Soup
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: REACH IN FRIDGE
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8046221007 of 01/27/22.

Certified Food Protection Manager: Shiela M Lago

Certification Number: 100923 Expires: 09/30/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
Dianna Lucas
Manager

Signed: 8046
Inspector 8046

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