Electronically Delivered

October 29, 2024

Licensee
Eastwood Assisted Living
170 Valhalla Circle
Mora, MN 55051

RE: Project Number(s) SL30743016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 8, 2024, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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

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
	30743	A. BUILDING: _____ B. WING _____	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTWOOD ASSISTED LIVING	170 VALHALLA CIRCLE MORA, MN 55051

(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: SL30743016-0 On October 7, 2024, through October 8, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 28 residents; 28 receiving services under the Assisted Living Facility with Dementia Care 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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 7, 2024, 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 to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents:	0 485		

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0 485	Continued From page 2 (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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. 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: During the entrance conference on October 7, 2024, at 10:51 a.m., licensed assisted living	0 485		

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0 485	Continued From page 3 director (LALD)-A stated the licensee provided residents three meals per day and the licensee offered resident's a meal plan separate from the contract. On page six of the [licensee name] Assisted Living Contract, Section 2 (two) b: indicated meal plan was a service not included in the monthly rent, however, available from provider for an additional charge. On [license name] Meal Plan Addendum A indicated to select one of the following Meal/Food [sic] options. Meals charges as follows (per month): -Three (3) meals each day for (cost) per month or per your (resident) county contract, if applicable; or -No [sic] meal plan through [licensee name] Resident assisted living contract addendums lacked an option for residents to opt out of payment for one or two meals residents would not want. On October 7, 2024, at 2:21 p.m., registered nurse (RN)-C stated all residents were offered to choose three meals per day or opt out of all meals. RN-C further stated since the licensee was a dementia care facility, all three meals would need to be provided to each resident daily, and was not aware the licensee needed to offer the option to offer out of one or two meals the resident did not want. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated September 26, 2024, indicated the provider cannot have a blanket "one size fits all" meal	0 485		

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0 485	Continued From page 4 charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of	0 650		

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0 650	Continued From page 5 one employee (unlicensed personnel (ULP)-D). 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 October 7, 2024, at 10:58 a.m., registered nurse (RN)-C and housing manager (HM)-I stated the licensee was aware of the required contents of the employee record. ULP-D was hired on April 15, 2024, to provide assisted living services. On October 8, 2024, at 6:55 a.m., ULP-D stated ULP-D completed training and competency testing with RN-C. On October 8, 2024, at 6:57 a.m., the surveyor observed ULP-D provide scheduled medication administration for R4. ULP-D's record lacked the following competency evaluation documentation: -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; -standby assistance techniques and how to perform them;	0 650		

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0 650	Continued From page 6 -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. On October 8, 2024, at 2:43 p.m., RN-C stated the Memory Care Minnesota Orientation Checklist- Caregiver dated April 15, 2024, in ULP-D's file indicated ULP-D passed competency for the competencies listed above. The surveyor reviewed the Memory Care Minnesota Orientation Checklist-Caregiver and confirmed the following findings with RN-C, RN-J, and licensed assisted living director (LALD)-A: -ULP-D's record contained a three-page Memory Care Minnesota Orientation Checklist-Caregiver dated April 15, 2024, provided by the licensee's online training provider (Educare) signed by RN-C and ULP-D. -On page one of the checklist the following was written: -Courses marked with +++ have a skill assessment requirement | See Educare Skill Assessments and attach copy to demonstrate competency -On page three of the checklist the following was written: -As the instructor or supervising evaluator of the training, I attest that the employee successfully completed the training as described in this document as noted on the online transcript or knowledge assessments and delegated nursing tasks as documented on the Skill Assessment. Immediately following the review of ULP-D's employee record, RN-J stated the licensee did not have the RN document each Educare Skill	0 650		

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0 650	Continued From page 7 Assessment for ULP-D. LALD-A further stated the licensee had a pass or fail competency skills assessment that was being implemented with new ULPs. The licensee's 4.05 Employee Records policy dated April 1, 2024, indicated employee records would include record of competency testing as required. The licensee's 5.02 Competency Training Evaluations policy dated April 1, 2024, indicated a copy of all education, training, and competency testing shall be kept in each employee's personnel file. The licensee's 5.10 Training Records policy dated April 1, 2024, indicated [licensee name] would maintain a record of staff training and competency as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
01290 SS=C	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290		

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01290	Continued From page 8 (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were affiliated with the correct health facility identification (HFID) for one of 43 employees (registered nurse (RN)-G). 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: During the entrance conference on October 7, 2024, at 10:58 a.m., RN-C and housing manager (HM)-I stated the licensee was aware of the required contents of the employee record. RN-G was hired April 15, 2024, to provide direct care services to residents and supervision of staff at the facility. RN-G was licensed by the Minnesota Board of Nursing on October 16, 2001. Upon review of the licensee's Minnesota Department of Human Services NETStudy 2.0 Roster HFID 30743, RN-G was affiliated with the	01290		

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01290	Continued From page 9 licensee on October 7, 2024 (after the initiation of the survey). On October 7, 2024, at 2:19 p.m., licensed assisted living director (LALD)-A stated RN-G was not affiliated with the licensee until the surveyor requested the licensee's NETStudy 2.0 roster. LALD-A stated LALD-A instructed human resources to affiliate RN-G to the licensee's NETStudy 2.0 roster after realizing RN-G was not listed. LALD-A further stated the licensee was aware all employees needed to be affiliated with each facility employees worked at, and RN-G had cleared NETStudy 2.0 background studies ran under a sister facility HFID. The licensee's 4.02 Background Studies policy dated April 1, 2024, indicated [licensee name] would conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors [sic] at [licensee name]. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services;	01470		

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01470	Continued From page 10 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01470		

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01470	Continued From page 11 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of three employees (unlicensed personnel (ULP)-F). 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: During the entrance conference on October 7, 2024, at 10:58 a.m., registered nurse (RN)-C and housing manager (HM)-I stated the licensee was aware of the required contents of the employee record. ULP-F was hired June 27, 2024, from a contract agency, to provide direct care services to residents at the facility. ULP-F's employee record lacked training for the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff.	01470		

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01470	Continued From page 12 On October 8, 2024, at 11:42 a.m., HM-I stated HM-I completed orientation to assisted living with agency staff upon hire. On October 8, 2024, at 11:57 a.m., the surveyor reviewed the topics provided during orientation to assisted living with HM-I and licensed assisted living director (LALD)-A. HM-I and LALD-A stated person-centered planning and service delivery was not a topic covered during the orientation to assisted living and all agency staff would be missing the person-centered planning and service delivery training. The licensee's 5.01 Orientation of Staff and Supervisor and Content [sic] policy dated April 1, 2024, indicated all staff providing direct care services must complete orientation to Assisted Living, which included the topic of principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30743	A. BUILDING: _____ B. WING _____	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTWOOD ASSISTED LIVING	170 VALHALLA CIRCLE MORA, MN 55051

(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
01620	Continued From page 13 (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident reassessment and monitoring completed by a registered nurse (RN) was conducted no more than 14 calendar days after initiation of services for one of three residents (R5). 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 October 7,	01620		

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	30743	A. BUILDING: _____ B. WING _____	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 14 2024, at 10:52 a.m., clinical nurse supervisor (CNS)-B stated the licensee completed resident assessments on preadmission, on admission, within 14 days of admission, and then at least every 90 days or a resident change of condition. R5 was admitted to the facility on April 22, 2024. R5's Admission Assessment dated April 22, 2024, was completed by RN-C. On October 8, 2024, at 7:19 a.m., the surveyor observed unlicensed personnel (ULP)-D complete scheduled morning medication administration for R5. R5's record contained a 14-day assessment dated May 7, 2024, was completed by RN-C, however, was completed 15 days after R5 was admitted to the facility. R5's record lacked a 14-day assessment conducted no more than 14 calendar days after the initiation of services. On October 8, 2024, at 3:11 p.m., RN-C stated R5's 14-day assessment was completed one day late and was not sure why since the licensee's electronic medical record prompts the RN when to complete resident assessments. The licensee's 6.01 Assessments, Reviews and Monitoring policy dated April 1, 2024, indicated resident reassessment and monitoring must be conducted more than 14 calendar days after initiation of services. The licensee's 6.02 Assessment Schedules policy dated April 1, 2024, indicated a resident reassessment and monitoring would be	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30743	A. BUILDING: _____ B. WING _____	10/08/2024

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EASTWOOD ASSISTED LIVING	170 VALHALLA CIRCLE MORA, MN 55051

(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
01620	Continued From page 15 completed by a RN and occur no more than 14 calendar days after the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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 management services; and (7) any resident-specific requirements relating to	01730		

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	30743	A. BUILDING: _____ B. WING _____	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTWOOD ASSISTED LIVING	170 VALHALLA CIRCLE MORA, MN 55051

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01730	Continued From page 16 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 plan for each resident to include all required content for one of three residents (R2). 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 October 7, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. R2's diagnoses included Alzheimer's disease with late onset, diabetes, and hypertension (HTN-high	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30743	A. BUILDING: _____ B. WING _____	10/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTWOOD ASSISTED LIVING	170 VALHALLA CIRCLE MORA, MN 55051

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01730	Continued From page 17 blood pressure). R2's service plan dated July 1, 2024, indicated R2's services included medication assistance eight times per day. R2's prescriber orders dated April 15, 2024, included an order for Basaglar insulin inject 18 units daily. On October 8, 2024, at 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-E complete scheduled morning medication administration for R2. During the observation, ULP-E handed R2 the Basaglar insulin pen that was dialed to 18 units, R2 self-administered the insulin, and handed the Basaglar insulin pen back to ULP-E. R2's 90-day Assessments dated May 16, 2024, and August 13, 2024, respectively, indicated R2 needed help with injectable meds (medications) and Med (medication) Self-Admin (administration) was not applicable. R2's individualized medication management plan was not current to reflect R2 was assessed by the registered nurse (RN) to complete self-administration of insulin. On October 8, 2024, at 2:47 p.m., RN-C stated RN-C was not aware R2 was self-administering insulin. RN-C further stated R2 should have been assessed to ensure R2 could safely self-administer insulin. The licensee's 7.15 Medication and Treatment Administration and Delegation policy dated April 1, 2024, indicated the RN must conduct a face-to-face resident assessment to determine what medication management ... will be provided	01730		

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	30743	A. BUILDING: _____ B. WING _____	10/08/2024

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01730	Continued From page 18 and how those services will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription drug supply for one of one resident (unknown resident) were not saved for use by anyone other than the resident for which the medication was prescribed. 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: During the entrance conference on October 7, 2024, at 10:50 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management to residents at the facility. On October 8, 2024, at 3:02 p.m., the surveyor	01900		

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01900	Continued From page 19 was in the nurse's office with CNS-B, registered nurse (RN)-C, licensed assisted living director (LALD)-A, and unlicensed personnel (ULP)-H. ULP-H stated to the surveyor "I (ULP-H) have something to show you (surveyor) that most aides (ULPs) are not comfortable with." ULP-H opened the top left hand draw on the desk CNS-B was seated at and pointed at a teal circle container with a clear top that had written in black permanent marker "Put Extra Tylenol here from ..." and the name that was written was scribbled out and unreadable with the black permanent marker. The container contained 81 white oblong pills (some pills were ½ tablets) with the imprint of G551. ULP-H stated it was Tylenol that was not used from an unidentified resident and exited the nurse's office. On October 8, 2024, at 3:03 p.m., RN-C stated the Tylenol was from a prescription bubble pack issued by the pharmacy for an unidentified resident. RN-C further stated the unidentified resident had three Tylenol tablets in the bubble pack for each administration, when only two Tylenol tablets were prescribed, so ULPs placed the one extra tablet in the teal container for an unknown reason. On October 8, 2024, at 3:05 p.m., CNS-B stated CNS-B did not know why the Tylenol pills were stored in the teal container or what the Tylenol pills were used for. CNS-B further stated the teal container with Tylenol had been stored in the desk before CNS-B started (September 3, 2024). RN-C further stated the Tylenol should have been disposed of and documentation of the disposition of Tylenol should have been completed. The licensee's 7.23 Medication Disposal policy dated April 1, 2024, indicated current unused	01900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01900	Continued From page 20 medications managed by [licensee name] will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *10/07/24*
Time: 11:00:42
Report: 1046241241

Food and Beverage Establishment Inspection Report

Location:
Eastwood Assisted Living
170 Valhalla Circle
Mora, MN55051
Kanabec County, 33

Establishment Info:
ID #: 0038591
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3206792916
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.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C ***** Priority 2 *****

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.

OBSERVED HOUSEHOLD MOUSE TRAPS IN THE DRY STORAGE AREA. REMOVE HOUSEHOLD MOUSE TRAPS AND USE APPROVED TRAPS.

Comply By: 10/07/24

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

VARIOUS PASTA, CEREAL, AND RICE WERE IN BULK CONTAINERS WITH NO LABELS. LABEL CONTAINER WITH CONTENTS WHEN REMOVED FROM ORIGINAL PACKAGING.

Comply By: 10/07/24

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

OBSERVED MULTIPLE WET CONTAINERS STACKED TOGETHER. ALLOW CONTAINERS TO FULLY DRY BEFORE STACKING.

Comply By: 10/07/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: BUCKET IN KITCHEN
Violation Issued: No

Hot Water: = at 160.3 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: STUFFING
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: POTATO SOUP
Violation Issued: No

Process/Item: Cooking
Temperature: 198 Degrees Fahrenheit - Location: ZUCCHINI
Violation Issued: No

Process/Item: Cooking
Temperature: 171 Degrees Fahrenheit - Location: PORK CHOPS
Violation Issued: No

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

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 1046241241 of 10/07/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Nicole Larrison
Public Health Sanitarian
St. Cloud
320-472-0042
nicole.larrison@state.mn.us

Report #: 1046241241

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

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

Date 10/07/24
Time In 11:00:42
Time Out

Eastwood Assisted Living	Address: 170 Valhalla Circle	City/State: Mora, MN	Zip Code: 55051	Telephone: 3206792916
License/Permit #: 0038591	Permit Holder	Purpose of Inspection: Full	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

		Compliance Status				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	X				Food properly labled; original container		
Prevention of Food Contamination							
38	X				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	X	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		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:** 10/07/24

Inspector (Signature)