Electronically Delivered

August 7, 2024

Licensee
Pierz Meadow Ponds Inc.
305 Ronald Avenue
Pierz, MN 56364

RE: Project Number(s) SL30431015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30431	A. BUILDING: _____ B. WING _____	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIERZ MEADOW PONDS INC	305 RONALD AVENUE PIERZ, MN 56364

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders were issued pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30431015-0 On July 8, 2024, through July 12, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were 18 residents, 18 receiving services under the provider's Assisted Living license.	0 000	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 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 July 8, 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 observation, interview, and record review, the licensee failed to prepare a menu a week in advance that was made available to all residents. This had the potential to affect all residents of the facility. 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 observation on July 8, 2024, at 1:04 p.m., the surveyor observed a posted weekly menu in the dining room near the entrance to the kitchen.	0 485		

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0 485	Continued From page 3 The posted menu included meals through July 10, 2024. The surveyor did not observe any additional posted weekly menus. On July 11, 2024, at 9:18 a.m., licensed assisted living director (LALD)-A stated the person responsible for creating weekly menus typically prepared them midweek to midweek, and no further menus were prepared at this time. LALD-A further stated that the culinary department was recovering after a leadership crisis and doing their best. LALD-A stated the licensee's best practice was to prepare a menu one month in advance. The licensee's 7. Food Service policy dated August 1, 2021, indicated menus would be prepared at least one week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to display the original current license at the main entrance of the facility as required. This had the potential to affect all residents, staff, and visitors.	0 570		

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0 570	Continued From page 4 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 the residents). The findings include: On July 8, 2024, at 11:58 a.m., during a facility tour, the surveyor observed the current assisted living facility license was not posted at the facility main entrance as required. The surveyor observed the posted assisted living facility license expired on May 31, 2024. On July 11, 2024, at 9:18 a.m., licensed assisted living director (LALD)-A stated she was unaware the posted assisted living facility license was expired. LALD-A stated she knew the licensee had the current assisted living facility license and she would get it posted. The licensee's 2.13 Assisted Living License and Posting policy dated August 1, 2021, indicated the original current license would be displayed at the main entrance of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 5 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect more than a limited number of 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a	0 780		

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0 780	Continued From page 6 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 11, 2024, at 1:15 p.m., survey staff toured the facility with maintenance (M)-G. During the tour, M-G tested smoke alarms in resident apartments. Survey staff observed the following: -In resident apartment 103, when the smoke alarm installed outside the bedroom was tested, the bedroom smoke alarm did not actuate. -In resident apartment 117, when the bedroom smoke alarm was tested, the smoke alarm installed outside the bedroom did not actuate. The dwelling unit smoke alarms were not interconnected in resident apartments 103 and 117. During the facility tour interview, M-G verified the smoke alarms were not interconnected in the one-bedroom apartments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 800		

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0 800	Continued From page 7 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 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 11, 2024, at 1:15 p.m., survey staff toured the facility with maintenance (M)-G. During the tour, survey staff observed the following: 1. Door closers had been removed from labeled one-hour fire doors for the laundry, kitchen, and whirlpool rooms. 2. The door closer had been removed from the labeled twenty-minute fire door leading from the corridor into the public restroom. These doors did not self-close and positively latch. Fire rated doors must be maintained as designed to protect the opening in which they were installed and to protect adjacent spaces. During the facility tour interview, M-G verified these door closers had been removed. 3. The labeled one-hour fire door leading from the corridor into the kitchen was propped open. The	0 800		

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0 800	Continued From page 8 labeled fire door leading from the corridor into the beauty salon was propped open. 4. Labeled 20-minute fire doors leading from the corridor into resident dwelling units were propped open with kick down door stops for resident rooms 101, 103, and 109. Fire doors held open by door stops or wedges prohibit the required operation and closing feature of the door. During the facility tour interview, M-G verified these fire doors were propped open. 5. The inspection tag attached to the reduced pressure device (RPZ) in the mechanical room was dated 2017. During the facility tour interview, M-G verified the RPZ had not been inspected annually by certified personnel as required. 6. One exit door did not positively latch when closing. During the facility tour interview, M-G verified the door was not latching properly. 7. A window blind was installed on the exit door in the dining room. Means of egress doors shall be easily recognizable as doors and not concealed by blinds. During an interview on July 11, 2024, at 2:45 p.m., licensed assisted living director (LALD)-A verified the window blind installation on the exit door and stated this blind would be removed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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:	0 810		

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0 810	Continued From page 9 (1) location and number of resident sleeping 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 record review and interview, the licensee failed to provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 10 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 potential to affect a large portion or all of the residents). The findings include: On July 11, 2024, maintenance (M)-G and licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. TRAINING Record review indicated that the licensee failed to provide training to employees on the facility FSEP upon hire and/or at least twice per year evident by the lack of documentation to support that this training had been completed. No employee training records were provided. During an interview on July 11, 2024, at 2:45 p.m., LALD-A stated employee records for FSEP training were not available and explained the previous facility director had recently left. LALD-A stated employees were trained on the FSEP at the time of hire and annually during in-service training on emergency preparedness. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill reports. Four employee fire drills were recorded in 2023. The 2023 drills were conducted in March, June, September, and December. The March and June drills were	0 810		

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0 810	Continued From page 11 completed during the day shift. The September and December drills were completed during the evening shift. Five employee fire drills were recorded in 2024. The 2024 drills were conducted in February, March, and July. Two 2024 drills were completed during the day shift, two during the evening shift, and one during the night shift. Fire drills were not conducted at a frequency of every other month and only one night shift drill was completed in the past year. During an interview on July 11, 2024, at 2:45 p.m., LALD-A verified the evacuation drill frequency was not met and confirmed at least two night shift drills were required each year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=D	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. (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.	01290		

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01290	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the licensee's health facility identification (HFID) number for one of three employees (unlicensed personnel (ULP)-E). 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: The licensee's assisted living facility license was issued on August 1, 2021, with a HFID of 30431. ULP-E was hired on March 7, 2018. The Minnesota Department of Human Services NETStudy 2.0 website dated July 8, 2024, at 1:49 p.m., indicated ULP-E had two cleared background studies affiliated with HFID 23849 (another license owned by the licensee's owner). ULP-E's record lacked a background study affiliated with the licensee's HFID 30431 where ULP-E provided care to residents. On July 9, 2024, at 12:22 p.m., licensed assisted living director (LALD)-A stated the licensee did not have a background study affiliated with the licensee's HFID for ULP-E. LALD-A stated it must have been an oversight or deleted	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30431	A. BUILDING: _____ B. WING _____	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIERZ MEADOW PONDS INC	305 RONALD AVENUE PIERZ, MN 56364

(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
01290	Continued From page 13 somehow as she thought she moved everyone's background study over after the assisted living conversion on August 1, 2021. The licensee's 3.38 Background Checks policy dated August 1, 2021, indicated the licensee would complete a Minnesota Department of Human Services Background Study on all employees being considered for hire. The policy did not indicate background studies must be affiliated with the licensee's HFID. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately document	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30431	A. BUILDING: _____ B. WING _____	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIERZ MEADOW PONDS INC	305 RONALD AVENUE PIERZ, MN 56364

(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
01760	Continued From page 14 medications administered for one of six residents (R4). 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: On July 9, 2024, at 6:11 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare the following medications for administration to R4 at a medication cart in the hallway outside R4's room: -acetaminophen 325 milligrams (mg) take two tablets twice daily; -aspirin 81 mg take daily; -metformin 1000 mg daily; -polyethylene glycol 17 grams (g) daily (mixed with water); -Senna S 8.6-50 mg twice daily; -vitamin D3 2000 international units (iu) daily; -Lantus Solostar insulin 18 units every morning; and -Humalog insulin sliding scale 4 units three times daily prior to meals. ULP-D gathered all medications and supplies and entered R4's room. ULP-D woke R4 and assisted him to sit on the edge of his bed. ULP-D administered R4's two insulin medications in separate locations on R4's abdomen. ULP-D administered R4's oral medications whole in applesauce. ULP-D then assisted R4 to lay back down in bed. ULP-D placed R4's polyethylene	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30431	A. BUILDING: _____ B. WING _____	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIERZ MEADOW PONDS INC	305 RONALD AVENUE PIERZ, MN 56364

(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
01760	Continued From page 15 glycol mixed in water on a table in R4's bedroom. As she was exiting R4's room, ULP-D stated R4 liked to drink the polyethylene glycol mixture after he get up from bed for the day. ULP-D then proceeded back to the medication cart and documented all medications, including polyethylene glycol, as administered. R4 admitted to the licensee on May 30, 2017, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R4's diagnoses included weakness, degenerative joint disease, hypertension, Diabetes Mellitus, and history of stroke. R4's service plan dated February 21, 2024, indicated R4 received assistance with medication administration, blood glucose monitoring, behavior management - orientation, dressing, grooming, toileting, bathing, transfers, mobility, housekeeping, and laundry. R4's registered nurse (RN) assessment dated May 17, 2024, indicated R4 required assistance with taking medications. The assessment further indicated ULPs were to deliver medication to R4, provide liquids, and monitor that medications were swallowed. The assessment also indicated medication self-administration was not applicable for R4. ULP-D's Medication Administration - Routes competency dated December 11, 2023, indicated ULP-D was deemed competent by clinical nurse supervisor (CNS)-C for the delegated task of medication administration. The competency instructed ULP-D to observe a resident swallow medication, then document administration	01760		

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	30431	A. BUILDING: _____ B. WING _____	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIERZ MEADOW PONDS INC	305 RONALD AVENUE PIERZ, MN 56364

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01760	Continued From page 16 afterwards. On July 9, 2024, at 1:16 p.m., ULP-D stated she knew she made a mistake leaving R4's polyethylene glycol mixture on a table unattended in R4's room and documenting it as administered. ULP-D stated she should have observed R4 swallow the polyethylene glycol mixed with water as that was how she was trained the RN. On July 11, 2024, at 9:44 a.m., CNS-C stated ULP-D told her what had happened during medication administration observation with R4's polyethylene glycol. CNS-C stated ULPs should not leave a resident with medications unless the resident has been assessed as appropriate for self-administration. CNS-C said ULPs should not document medications were administered until the medications were observed as administered. The licensee's 12.25 Medication and Treatment: Administration and Delegation policy dated August 1, 2021, indicated prior to delegating the task of medication administration, a RN must instruct a ULP on preparation, administration, and documentation after assistance with medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30431	A. BUILDING: _____ B. WING _____	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIERZ MEADOW PONDS INC	305 RONALD AVENUE PIERZ, MN 56364

(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
01910	Continued From page 17 part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of a medication that was discontinued for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 observation of the medication storage refrigerator on July 10, 2024, at 12:45 p.m., the surveyor observed Novolog insulin for R3,	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30431	A. BUILDING: _____ B. WING _____	07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 18 dispensed from the pharmacy on July 31, 2023. Licensed practical nurse (LPN)-B stated she knew R3's Novolog had been discontinued a while ago. LPN-B stated she saved the medication in case it was ordered again as R3's pharmacy takes "so long to fill [prescriptions]." R3 was admitted to the licensee on February 10, 2023, and began receiving assisted living services. R3's diagnoses included chronic kidney disease, depression, hypothyroidism, degenerative joint disease, hypertension, and Diabetes Mellitus type 2. R3's service plan dated June 13, 2024, indicated R3 received assistance with medication administration, behavior management - hallucination, behavior management - orientation, dressing, grooming, toileting, bathing, mobility, housekeeping, and laundry. R3's prescriber's order dated April 19, 2024, indicated Novolog insulin was discontinued due to not being administered regularly. On July 11, 2024, at 9:44 a.m., clinical nurse supervisor (CNS)-C stated she remembered instructing LPN-B to destroy R3's Novolog after it was discontinued by the prescriber. CNS-C stated if R3 had the medication prescribed again, a new prescription would be sent to the pharmacy by R3's prescriber, and a new prescription would be filled by the pharmacy. CNS-C stated the licensee tried to destroy medications weekly, but sometimes it took longer. CNS-C stated R3's Novolog should not have been present in the medication refrigerator three months after it was discontinued.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 19 The licensee's 12.39 Medication Disposal policy dated August 1, 2021, indicated the licensee would dispose of any medications remaining in the building that were discontinued according to state and federal regulations for disposition of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *07/08/24*
Time: 12:44:24
Report: 1017241108

Food and Beverage Establishment Inspection Report

Location:
Pierz Meadow Ponds Inc
305 Ronald Avenue
Pierz, MN56364
Morrison County, 49

Establishment Info:
ID #: 0039202
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3204688280
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.

HOT WATER DISH MACHINE DID NOT MEET MINIMUM REQUIRED TEMPERATURE. PROVIDE MACHINE THAT MEETS 160 DEGREE MINIMUM TEMPERATURE REQUIREMENT IN ABOVE RULE.

Comply By: 07/08/24

4-300 Equipment Numbers and Capacities

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

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

PROVIDE THERMOMETER FOR DISH MACHINE.

Comply By: 07/08/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

EMPLOYEE CFPM, ADDIE HAS HER SERVE SAFE CERTIFICATE/CREDENTIAL BUT SHE NEEDS TO APPLY FOR THE STATE ISSUED CFPM CERTIFICATE.

Comply By: 07/08/24

Type: Full
Date: *07/08/24*
Time: 12:44:24
Report: 1017241108
Pierz Meadow Ponds Inc

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Hot Water: = at 157 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 42 Degrees Fahrenheit - Location: COOL WHIP LOCATED IN UPRIGHT COOLER
Violation Issued: No

Process/Item: Cooking
Temperature: 203 Degrees Fahrenheit - Location: MEAT BALLS LOCATED IN OVEN
Violation Issued: No

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

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG, TIME AND TEMPERATURE CONTROL FOR SAFETY - PDF SENT WITH REPORT.

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 1017241108 of 07/08/24.

Certified Food Protection Manager: ADDIE HASERT

Certification Number: _____ Expires: 03/18/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017241108

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/08/24
Time In 12:44:24
Time Out

Pierz Meadow Ponds Inc	Address: 305 Ronald Avenue	City/State: Pierz, MN	Zip Code: 56364	Telephone: 3204688280
License/Permit #: 0039202	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
Surpervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	IN	(OUT)	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 07/08/24

Inspector (Signature)