DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 9, 2023

Licensee
Heritage Cottage on 6th
611 West 6th Street
Park Rapids, MN 56470

RE: Project Number(s) SL26536015

Dear Licensee:

On January 4, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the November 30, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

Electronically Delivered

December 12, 2022

Administrator
Heritage Cottage on 6th
611 West 6th Street
Park Rapids, MN 56470

RE: Project Number(s) SL26536015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 30, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#26536015 On, November 28, 2022, through November 30, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 30 residents: 18 whom were receiving services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on November 30, 2022, issued for SL#26536015, tag identification 1290. On November 30, 2022, at 1:10 p.m., the immediacy of correction order 1290 was removed, however, non-compliance remained at a scope and level of H.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 28, 2022, at 9:30 a.m., licensed assisted living director (LALD)-B stated the licensee's	0 250		

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0 250	Continued From page 3 employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent (AA)-K, identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	0 250		

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0 250	Continued From page 4	0 250		

conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license.

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.

- I have examined this application and all attachments and checked the above boxes

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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorizing agent (AA)-K on May 25, 2022. The licensee had an assisted living license reissued on August 1, 2022, with an expiration date of July 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication management; and - supervision of unlicensed personnel performing delegated tasks As a result of this survey, the following orders were issued 0250, 0480, 0620, 0650, 0660, 0970, 0980, 1290, 1420, 1440, 1470, 1500, 1540, 1690,	0 250		

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0 250	Continued From page 6 1730, 1770, 1880, 1890, 1910, 1920, 2040, 2310, 3000, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 7 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 29, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an unaccounted narcotic loss from a stock medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 620		

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0 620	Continued From page 8 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 November 28, 2022, at 10:20 a.m., during the entrance conference consulting registered nurse (RN-D) stated all narcotic medication was double locked in a cabinet and counted by two staff members at the end/start of each shift. The staff members document this reconciliation in the narcotic book (a paper record which documents the removal and addition of the identified controlled substance) and if the count was off, they should contact the RN and the licensee's Loss and Spillage policy would be followed. On November 28, 2022, at 12:04 p.m., the locked medication cupboard in the nursing office was reviewed with LPN-A, RN-C, and consulting RN-D. LPN-A and consulting RN-D looked at the stock Hospice Emergency Supply bottle of morphine sulfate 100 milligrams/5 milliliters (mg/ml) which was placed on top of the nursing desk, and both visualized the side of the morphine bottle and stated the amount in the bottle was 26 ml. LPN-A stated the bottle of morphine sulfate had been opened. The Individual Narcotic Record for the Hospice Emergency Supply morphine sulfate 100 mg/5 ml (page 79 of the bound narcotic book) was reviewed with LPN-A, RN-C, and consulting RN-D. LPN-A stated the last time the Hospice Emergency Supply bottle of morphine sulfate had been counted was on January 3, 2022, at 11:00 a.m., and was recorded as having a remaining	0 620		

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0 620	Continued From page 9 amount of 30 ml. This entry had been signed by RN-C (no witness signature). LPN-A stated she did not have any other narcotic log counting form for this medication. At 12:10 p.m., LPN-A and RN-C stated they were unable to account for the missing 4 ml of morphine sulfate. At 12:19 p.m., consulting RN-D pulled up the licensee's Controlled Substances/Scheduled II Drugs policy dated August 1, 2021, on her laptop and recited from the policy that "assisted living staff, including a licensed nurse whenever possible, will use a preferred practice of counting controlled drugs at the end of each shift if medications are stored securely outside of the resident's room. The staff person coming on duty and the staff person going off duty will count the controlled medications together and will document and report any discrepancies immediately to the RN." Consulting RN-D stated narcotics should be counted after each shift per the licensee's policy and the policy had not been followed. On November 28, 2022, at 12:30 p.m., RN-C stated to the surveyors that LPN-A had drawn up nine syringes of morphine sulfate for R5 out of the Hospice Emergency Supply on October 21, 2022, and not recorded it in the narcotic book. RN-C stated they had made the corrections in the narcotic book and all the morphine was accounted for. The surveyor requested from RN-C the documentation of the above noted incident and investigation. A brief review of R5's record included the following: R5's service plan dated September 28, 2021, indicated the resident received medication management services to include medication administration.	0 620		

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0 620	Continued From page 10 R5's medication management assessment dated July 28, 2022, noted R5's narcotic and scheduled medications were kept double locked in the service room and were signed out with two staff. The RN reviews the narcotic book with LPN to ensure all medications are accounted for monthly. R5's prescriber orders dated October 12, 2022, included an order for morphine (a moderate to severe controlled substance pain reliever) 2 mg to be administered inside the cheek three times a day and every one hour as needed for pain/dyspnea (difficult or labored breathing). R5's nursing progress notes dated October 17, 2022, at 8:09 a.m., written by LPN-A noted the writer [LPN-A] had received a phone call at 6:20 a.m., that R5 had passed peacefully. RN-C provided the revised narcotic logs for R5's morphine sulfate and the Hospice Emergency Supply morphine sulfate log. A review of the Individual Narcotic Record Hospice Emergency Supply for morphine sulfate 100 mg/5 ml's (page 79 of the bound narcotic book) indicated the following: - entry dated January 3, 2022, at 11:00 a.m., amount remaining - 30 ml; "counted" and signed by RN-C - entry dated November 28, 2022, (no time) noted "see page 108 - drew up 9 doses of ½ cc [0.5 cubic centimeter which is equivalent to 0.5 ml which is equivalent to 10 mg of morphine] for [name of resident R5] October 21, 2022". [R5's order for morphine sulfate dated October 12, 2022, was for 2 mg (0.1 ml) to be administered three times daily and every one hour as needed]. - the next line it was documented the amount remaining was 25.5 ml left in bottle and co-signed by RN-C and LPN-A.	0 620		

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	26536	A. BUILDING: _____ B. WING _____	11/30/2022

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0 620	Continued From page 11 A review of R5's Individual Narcotic Record [page 108] indicated under the name of the medication and dose "morphine" [no dosage listed] indicated on October 21, 2022, at 1:20 p.m., under the dose column "2 mg" [which is equivalent to 0.1 ml of the morphine concentration of 100 mg/5ml]; under the amount remaining column "9 syringes" and co-signed by LPN-A and RN-C. On the next line (no date or time or signature after the entry) it was noted "drawn up from stock bottle and transferred to RA [resident assistance] book" and documented under the amount remaining "0". As noted above R5 had passed away on October 17, 2022. A review of R5's Individual Narcotic Record in the service room [which is the RA book mentioned above] indicated under the name of the medication and dose "morphine sulfate" and the directions for use 2 mg (0.1 cc) three times per day and 2 mg (0.1 cc) as needed every hour. On October 13, 2022, 20 syringes were received; and 2 mg prefilled syringes were administered as ordered from October 13 - 16, 2022. The entry dated October 16, 2022, at 7:00 p.m., indicated there were 9 syringes of morphine remaining. The next entry was dated October 21, 2022, at 1:20 p.m. - the dose noted to be 2 mg and the amount remaining was "0" and this was signed by LPN-A. The next line on this log had a line through the next row. The last documented line (no date or time) indicated "placed [illegible scribble] in main office lock box d/t [due to] resident expired" this entry was co-signed by LPN-A and RN-C. On November 29, 2022, from 2:53 p.m. to 3:16 p.m., the surveyor conducted an interview with LPN-A, RN-C, and consulting RN-D. At 2:53 p.m., consulting RN-D reviewed R5's morphine sulfate	0 620		

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0 620	Continued From page 12 order and stated R5's order was for 2 mg of morphine to be given three times a day and every one hour as needed. At 2:54 p.m., RN-C and LPN-A reviewed R5's October 2022, medication administration record (MAR) and stated R5 had received a total of 12 doses with three additional doses marked as not given [indicated by a circle around the date/time/initial a scheduled dose was to be given]. However, there was no documentation of why these three doses had not been given. At 2:58 p.m., LPN-A stated she had drawn up 20 - 2 mg (0.1 cc) morphine syringes for R5 on October 13, 2022, and put them in bundles of five and had placed them in the narcotic box in the "RA" room. LPN-A stated she had not documented this medication setup for R5's morphine. In response to the entry dated November 28, 2022, in the above noted Hospice Emergency Supply narcotic book LPN-A stated she had not drawn up 9 syringes of morphine for R5, she had removed the 9 syringes that were in the narcotic box and put them in the nursing office narcotic box because the resident had expired. RN-C stated she had documented on November 28, 2022, in the Hospice Emergency Supply morphine narcotic log that 9 doses of ½ cc syringes had been drawn up [which would have been 10 mg of morphine per dose compared to R5's provider order that 2 mg (0.1 cc) should be administered] because that "equaled the amount of morphine that was missing". RN-C stated, "I can't answer anymore of how many were drawn up at this point everything is confusing". At 3:07 p.m., RN-C stated the documentation she made yesterday (November 28, 2022) was "incorrect". At 3:12 p.m., RN-C stated at this time we cannot account for the 4 ml of morphine sulfate 100 mg/5ml (equivalent to 80 mg of morphine sulfate) that is missing from the Emergency Hospice Supply	0 620		

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0 620	Continued From page 13 morphine bottle. On November 29, 2022, at 3:14 p.m., the surveyor asked for a copy of the incident report and investigation for the missing morphine. RN-C stated she had something partially "typed up" however, RN-C stated she would not provide the surveyor a copy. On November 29, 2022, at 3:16 p.m., consulting RN-D stated when a narcotic is unaccounted for this would be considered a reportable event and should be reported to the Minnesota Adult Abuse Reporting Center (MAARC) and stated an investigation does not have to be finished before a report is made to MAARC. RN-C stated they have up to 24 hours to report to MAARC [as noted above the missing narcotic was discovered on November 28, 2022, at 12:10 p.m., putting this at 27 hours after the discovery of the missing 4 ml - 80 mg of morphine sulfate]. RN-C stated a report had not been submitted to MAARC. On November 30, 2022, at 8:44 a.m., LALD-A stated a MAARC report had not been made. The licensee's Abuse Prevention Plan policy dated March 2022, noted incidents are reported, documented, and investigated internally using [corporate name] incident reporting policy and procedure. Not all incidents need to be reported to an outside agency. Incidents where it is determined that maltreatment may be occurred must be reported to the appropriate state agency. All alleged incidents or maltreatment are reported to the state agency and to all other agencies as required and all necessary corrective actions, depending on the results of the investigation, are taken. "Immediately" means as soon as possible, but not more than 24 hours after discovery of the	0 620		

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0 620	Continued From page 14 incident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three	0 650		

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0 650	Continued From page 15 years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all the required content for one of three employees (unlicensed personnel (ULP)-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-G started employment on December 2, 2012, and began providing assisted living services on August 1, 2021. On November 29, 2022, at 7:20 a.m., the surveyor observed ULP-G conduct a blood glucose check using a Libre monitoring system (a continuous glucose monitoring device which consists of a handheld reader and a sensor worn on the back of the upper arm) and administer R4's scheduled morning medications which included insulin administration. ULP-G's employee record lacked the following required training and competency evaluation documentation: - medication administration - insulin pen administration	0 650		

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0 650	Continued From page 16 - Libre monitoring system On November 30, 2022, at 5:02 p.m., licensed assisted living director (LALD)-B provided an email correspondence dated November 30, 2022, at 4:49 p.m., to LALD-B from consulting registered nurse (RN)-J attesting ULP-G had completed the above noted training and competency evaluations on March 9th and 10th, 2022. At 5:35 p.m., RN-J via a phone interview, stated the above noted training and competency had been completed but the documentation for this training had been "lost" as it had been given to a previous LALD. The licensee's Training Documentation policy dated August 1, 2021, noted a record of staff training and competency will be maintained. Each competency evaluation, training, retraining, and orientation topic will have the following documentation: - facility name and location - facility license number - training topic or training program - training methodology - date of the training and/or competency evaluation - total amount of time for the training and competency evaluation - name and title of the instructor - instructor's signature - name and tile of the competency evaluator, if different from the instructor - competency evaluator's electronic signature, if different from the instructor - evaluator statement attesting the employee successfully completed the training and competency evaluation - name and title of the staff person completing the training	0 650		

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0 650	Continued From page 17 - staff person's signature The licensee's Personnel Records policy dated August 1, 2021, noted personnel records will be kept up to date, well organized and confidential and will comply with the assisted living law and relevant laws. Personnel records will be retained for seven years after an employee or contractor ceases to be employed by the program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to complete a two-step	0 660		

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0 660	Continued From page 18 TST (tuberculin skin test) or other evidence of tuberculosis (TB) screening such as a blood test for one of two 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, 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: The facility's TB risk assessment was completed on November 14, 2022, and was determined to be a low risk level. On November 29, 2022, at 8:12 a.m., the surveyor observed ULP-F administer R8's scheduled morning medications. ULP-F was hired on August 9, 2021, to provide direct care services to the facility's residents. ULP-F's employee record included documentation of a negative TST on August 11, 2021; however, a second TST was not completed. On November 30, 2022, at 4:18 p.m., licensed assisted living director (LALD)-B stated ULP-F's second step TST had not been completed as required. The licensee's TB Prevention and Control policy dated August 1, 2021, noted the agency would follow the guidelines provided by Minnesota	0 660		

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0 660	Continued From page 19 Department of Health (MDH) related to the outcome of the risk assessment and the frequency of screening for current employees. Screening includes assessing for current symptoms of active TB; assessing for TB risk factors and TB history; and testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single interferon gamma release assay (IGRA-a medical test used in the diagnosis of TB). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. 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 include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a	0 970		

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0 970	Continued From page 20 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 the potential to affect a large portion or all the residents). The findings include: During the entrance conference on November 28, 2022, at 10:43 a.m., the surveyor asked for a copy of the licensee's assisted living contract. The assisted living contract was provided and later reviewed by the surveyor. The assisted living contract provided included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Page 12, section 31. Indemnification: Resident will indemnify and hold harmless the Community [facility], its employees and agents from and against any and all claims, actions, damages, and liabilities and expenses in connection with loss of life, personal injury or damage to property, arising from or out of the use of Resident of the Apartment or any other part of the Community's property, or caused wholly or in part by an act or omission of Resident. On November 29, 2022, at 2:42 p.m., licensed assisted living director (LALD)-B stated the licensee provided the same assisted living contract to all residents. LALD-B reviewed the Indemnification section of the assisted living contract noted above and stated the assisted living contract is a corporate document and there are a couple areas including the Indemnification section that is being re-evaluated.	0 970		

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0 970	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract's arbitration provision did not preclude, limit, or delay the ability of a resident from taking civil action. This practice resulted in a level one violation, 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 November 28, 2022, at 10:43 a.m., the surveyor asked for a copy of the licensee's assisted living contract. The assisted living contract was provided and	0 980		

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0 980	Continued From page 22 later reviewed by the surveyor. The assisted living contract provided included an arbitration section which precluded, limited, or delayed the ability of a resident from taking civil action. Page 13, section 34. Mandatory Dispute Resolution noted the following provisions govern how the Community [facility] and Resident will resolve disputes that may arise in connection with this Agreement. Please read it carefully, as it contains a waiver of your and our rights to take a civil action in a court of law. On November 29, 2022, at 2:42 p.m., licensed assisted living director (LALD)-B stated the licensee provided the same assisted living contract to all residents. LALD-B stated the assisted living contract is a corporate document and there are a couple areas including the section noted above that is being re-evaluated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 980		
01290 SS=H	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 23 (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 observation, interview and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for four of five employees, (unlicensed personnel (ULP)-F, ULP-G, ULP-I, licensed practical nurse (LPN)-A). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a pattern scope (when more than a 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: This resulted in an immediate correction order on November 30, 2022, at 11:48 a.m. ULP-F ULP-F was hired August 9, 2021, to provide direct care services to the facility's residents. On November 29, 2022, at 8:12 a.m., the surveyor observed ULP-F to administer R8's scheduled morning medications.	01290		

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01290	Continued From page 24 ULP-F's record lacked documentation of a background study. ULP-G ULP-G was hired December 2, 2012, to provide direct care services to the facility's residents. On November 29, 2022, at 7:20 a.m., the surveyor observed ULP-G to administer R4's scheduled morning medications which included insulin administration. ULP-G's record lacked documentation of a cleared background study affiliated with the facility's licensee. ULP-I ULP-I was hired on May 2, 2022, to provide direct care services to the facility's residents. ULP-I's record lacked documentation of a cleared background study affiliated with the facility's license. LPN-A LPN-A was hired on September 13, 2008, to provide direct care services to the facility's residents. LPN-A's record lacked documentation of a cleared background study affiliated with the facility's license. On November 30, 2022, at 11:31 a.m., licensed assisted living director (LALD)-B stated they did not have a background study completed for ULP-F. LALD-B stated the background studies are affiliated with the campus and not each individual facility license.	01290		

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01290	Continued From page 25 The licensee's Criminal and Background Check Policy dated November 1, 2021, noted to provide a safe and secure work environment for those we employ and serve, and to maintain compliance with state and federal regulations, all [corporation name] final applicants, current team members, and volunteers who will be providing direct contract services to vulnerable adults are required to have a background check completed. No further information provided. TIME PERIOD FOR CORRECION: Immediate Immediacy is removed as confirmed by evaluation supervisor on November 30, 2022, at 1:10 p.m., however, non-compliance remains at a scope and level of three, pattern (H). TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed	01420		

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01420	Continued From page 26 health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP-F) who utilized a sit to stand lift for transferring R7. 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: ULP-F was hired on August 9, 2021, to provide direct care services to the facility's residents. On November 28, 2022, at 2:15 p.m., the surveyor observed ULP-F and ULP-E, using appropriate technique transfer R7 from her wheelchair to the toilet using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). ULP-F's record lacked documentation to indicate ULP-F had received training and demonstrated competency for using the sit to stand lift. On November 30, 2022, at 5:08 p.m., RN-C stated they do not have any documentation that ULP-F had been trained and deemed competent	01420		

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01420	Continued From page 27 for using the sit to stand lift. RN-C stated I don't know if she did it or not. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted a RN may delegate nursing services, or an authorized Licensed Health Professional may delegate treatments or assign therapy tasks, to ULP that: i. have successfully completed the training required for ULP, ii. have trained in the services to be provided, iii. have demonstrated to the RN or Licensed Health Professional the ability to competently follow the procedures for the client and possess the knowledge and skills consistent with the complexity of the task No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the	01440		

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01440	Continued From page 28 interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one 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, 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 November 28, 2022, at 2:15 p.m., the surveyor observed ULP-F and ULP-E, using appropriate technique transfer R7 from her wheelchair to the toilet using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). On November 29, 2022, at 8:12 a.m., the surveyor observed ULP-F administer R8's scheduled morning	01440		

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01440	Continued From page 29 medications. ULP-F was hired on August 9, 2021, to provide direct care services to the facility's residents. ULP-F's employee record included a Notes on Supervision of Unlicensed Personnel dated July 14, 2022 and had ULP-F listed as the "client". ULP-F's employee record did not include documentation of a registered nurse (RN) supervising ULP-F performing a delegated task within 30 days of beginning work with the licensee. On November 30, 2022, at 5:06 p.m., licensed assisted living director (LALD)-B stated with regards to ULP-F's employee record "we gave you what we have". The licensee's Supervision of Licensed and Unlicensed Personnel policy dated August 1, 2021, noted an RN will supervise staff who perform delegated nursing, treatment or therapy services. Supervision of ULP's by an RN will be direct supervision of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	01470		

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01470	Continued From page 30 (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; (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	01470		

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01470	Continued From page 31 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 (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 observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of three employees (unlicensed personnel (ULP-G), 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 pattern scope (when more than a 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: ULP-G ULP-G started employment on December 2, 2012, and began providing assisted living services on August 1, 2021. On November 29, 2022, at 7:20 a.m., the surveyor observed ULP-G administer R4's	01470		

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01470	Continued From page 32 scheduled morning medications which included insulin administration. ULP-G's employee record did not include the following required orientation content: an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. ULP-F ULP-F was hired on August 9, 2021, to provide direct care services to the facility's residents. On November 28, 2022, at 2:15 p.m., the surveyor observed ULP-F and ULP-E, using appropriate technique transfer R7 from her wheelchair to the toilet using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). On November 29, 2022, at 8:12 a.m., the surveyor observed ULP-F administer R8's scheduled morning medications. ULP-F's employee record did not include the following required orientation content: - an overview of the 144 G statutes - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - a review of the types of assisted living services the employee will be providing and the facility's category of licensure, and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On November 30, 2022, at 1:28 p.m., licensed assisted living director (LALD)-B stated she would	01470		

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01470	Continued From page 33 look for the missing training for ULP-G and ULP-F. On November 30, 2022, at 5:06 p.m., LALD-B stated with regards to ULP-G and ULP-F's employee records "we gave you what we have". The licensee's Assisted Living Orientation - ULP Staff policy dated August 1, 2021, noted newly hired ULP will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500		

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01500	Continued From page 34 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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:	01500		

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01500	Continued From page 35 Based on observation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-G). 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: ULP-G started employment on December 2, 2012, and began providing assisted living services on August 1, 2021. On November 29, 2022, at 7:20 a.m., the surveyor observed ULP-G administer R4's scheduled morning medications which included insulin administration. ULP-G's employee record lacked evidence ULP-G successfully completed annual training as required to include a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On November 30, 2022, at 1:28 p.m., licensed assisted living director (LALD)-B stated she would look for the missing training for ULP-G. On November 30, 2022, at 5:06 p.m., LALD-B stated with regards to ULP-G's employee records	01500		

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01500	Continued From page 36 "we gave you what we have". The licensee's Assisted with Dementia Care Annual Training policy dated August 1, 2021, noted staff would complete annual education to keep knowledge and skills current to provide quality care to residents. All assisted living employees will complete annual education to include the following topic: a review of policies and procedures relating to the provision of assisted living services and how to implement them. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01540		

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01540	Continued From page 37 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP)-F) received the required amount of dementia care training in the required time frame. 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: The facility was licensed as an assisted living facility with dementia care. ULP-F was hired on August 9, 2021, to provide direct care services to the facility's residents. On November 28, 2022, at 2:15 p.m., the surveyor observed ULP-F and ULP-E, using appropriate technique transfer R7 from her wheelchair to the toilet using a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability). On November 29, 2022, at 8:12 a.m., the surveyor observed ULP-F administer R8's scheduled morning medications. ULP-F's employee records did not indicate a total of eight hours of required dementia training was completed within 80 hours of the employee's start	01540		

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	26536	A. BUILDING: _____ B. WING _____	11/30/2022

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HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

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01540	Continued From page 38 date. ULP-F's employee record indicated the employee had completed 3.5 hours of dementia training. On November 30, 2022, at 1:28 p.m., licensed assisted living director (LALD)-B reviewed ULP-F's training transcript and stated according to ULP-F's training transcript she had only completed 3.5 hours of dementia care training. LALD-B stated she would look for the missing training for ULP-F. On November 30, 2022, at 5:06 p.m., LALD-B stated with regards to ULP-F's employee record "we gave you what we have". The licensee's Assisted Living with Dementia Care Dementia Training policy dated August 1, 2021, noted assisted living staff will receive required training on dementia care during orientation and annually. Direct-care employees will complete a minimum of eight hours of initial training on dementia care topics. Initial training will be completed within 80 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop,	01690		

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01690	Continued From page 39 implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the security and accountability of controlled substances were maintained for three of three residents (R8, R9, R10) and one stock medication. 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	01690		

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01690	Continued From page 40 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: On November 28, 2022, at 10:20 a.m., during the entrance conference consulting registered nurse (RN-D) stated all narcotic medication was double locked in a cabinet and counted by two staff members at the end/start of each shift. The staff members document this reconciliation and if the count was off, they should contact the RN. On November 28, 2022, at 11:23 a.m., the surveyor toured the facility with licensed practical nurse (LPN)-A, including a review of the locked narcotic medication cupboard in the service room. The narcotic medication cupboard contained the following medications: - a blister pack (a transparent molded piece of plastic often sealed to a sheet of cardboard, used to package tablets) containing 15 morphine sulfate (narcotic pain reliever) 7.5 milligram (mg) tablets for R8 - a blister pack containing ten Lorazepam (sedative) 0.5 mg tablets for R8 - a blister pack containing 24 oxycodone (narcotic pain reliever) 5 mg tablets for R9 - a blister pack containing 11 hydrocodone (narcotic pain reliever) 5/325 mg tablets for R10 On November 28, 2022, at 11:25 a.m., LPN-A stated staff should be counting the narcotics with two staff members three times a day at the end/start of every shift and documenting that the counts were okay in the narcotic count book. The narcotic count book which was located on a shelf underneath the narcotic cupboard was reviewed	01690		

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01690	Continued From page 41 with LPN-A. The Controlled Drugs-Count Record had entries dated October 14, 2022, through November 18, 2022. LPN-A stated the last time the narcotics were documented as being counted was November 18th and before that they hadn't been counted since October 21, 2022 [out of the 138 opportunities for counting the narcotics there was documentation narcotics had been counted 15 times from October 14, 2022, to November 28, 2022]. LPN-A stated she would be talking to staff. On November 28, 2022, at 12:04 p.m., the locked medication cupboard in the nursing office was reviewed with LPN-A, RN-C and consulting RN-D. The locked narcotic cupboard contained, but was not limited to, one stock medication bottle of morphine sulfate 100 mg/5 milliliters which contained 26 ml. LPN-A stated we don't have a narcotic counting log for this medication. At 12:19 p.m., consulting RN-D pulled up the licensee's Controlled Substances/Scheduled II Drugs policy dated August 1, 2021, on her laptop and recited from the policy that "assisted living staff, including a licensed nurse whenever possible, will use a preferred practice of counting controlled drugs at the end of each shift if medications are stored securely outside of the resident's room. The staff person coming on duty and the staff person going off duty will count the controlled medications together and will document and report any discrepancies immediately to the RN." Consulting RN-D stated narcotics should be counted after each shift per the licensee's policy and the policy had not been followed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01690		

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01690	Continued From page 42 days	01690		
01730 SS=E	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 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	01730		

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01730	Continued From page 43 (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 interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for each resident to include all the required content for two of three residents (R6, 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) and was issued at a pattern scope (when more than a 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: During the entrance conference on November 28, 2022, at 10:19 a.m., consulting registered nurse (RN)-D stated the licensee provided medication management services to residents at the facility. R6 R6's diagnoses included atrial fibrillation (an irregular often rapid heartrate), hypertension (HTN-high blood pressure), and edema (swelling). R6's service plan dated August 20, 2022,	01730		

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01730	Continued From page 44 indicated R6 received medication administration services daily. R6's prescriber orders dated November 22, 2022, included an order for Coumadin (blood thinner) 1.25 milligrams (mg) to be administered every Tuesday and Thursday; 2.5 mg to be administered all other days. R6's November 2022, Medication Administration Record (MAR) noted the following specific instructions for the Coumadin: the Coumadin is set up in the daily medication box. On November 29, 2022, at 2:50 p.m., licensed practical nurse (LPN)-A stated she sets up R6's Coumadin every week on Tuesdays. R6's record lacked an incomplete medication management plan as R6's service plan dated August 20, 2022, lacked a written statement of the medication management services the resident received to include medication setup. On November 29, 2022, at 2:46 p.m., LPN-A stated R6's service plan does not include the service of medication setup. RN-C stated, "I will make the change". R5 R5's diagnoses included Parkinson's Disease (a chronic progressive neurological disease which exhibits symptoms such as tremors, rigidity, impaired balance, slowness of movement and a shuffling gait), chronic kidney disease, chronic pain, and muscle weakness. R5's service plan dated September 28, 2021, indicated the resident received medication administration services daily.	01730		

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01730	Continued From page 45 R5's prescriber orders dated October 12, 2022, included an order for morphine (a moderate to severe controlled substance pain reliever) 2 mg to be administered inside the cheek three times a day and every one hour as needed for pain/dyspnea (difficult or labored breathing). R5's Individual Narcotic Record dated October 13, 2022, through October 21, 2022, indicated on October 13, 2022, 20 morphine sulfate 2 mg (0.1 cubic centimeter) syringes had been placed in the narcotic lock box by LPN-A. On November 29, 2022, at 2:58 p.m., LPN-A stated she had drawn up (setup) 20 - 2 mg (0.1 cc) morphine syringes for R5 on October 13, 2022; and put them in bundles of five and had placed them in the narcotic box in the "RA" [service room] room. R5's record lacked an incomplete medication management plan as R5's service plan dated September 28, 2021, lacked a written statement of the medication management services the resident received to include medication setup. On November 30, 2022, at 8:50 a.m., RN-C stated R5's service plan does not include the service of medication setup. The licensee's Contents of Service Plans policy dated August 1, 2021, noted all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed health professional. The licensee's Documentation of Medication, Treatment and Therapy Management Services	01730		

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01730	Continued From page 46 policy dated August 1, 2021, noted the RN would document the services the client will receive on the client's individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R6, 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) 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: During the entrance conference on November 28, 2022, at 10:22 a.m., licensed practical nurse	01770		

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01770	Continued From page 47 (LPN)-A stated the licensee provided medication management services to include medication setup for R6. R6 R6's diagnoses included atrial fibrillation (an irregular often rapid heartrate), hypertension (HTN-high blood pressure), and edema (swelling). R6's service plan dated August 20, 2022, indicated R6 received medication management services. R6's prescriber orders dated November 22, 2022, included an order for Coumadin (blood thinner) 1.25 milligrams (mg) to be administered every Tuesday and Thursday; 2.5 mg to be administered all other days. R6's November 2022, Medication Administration Record (MAR) noted the following specific instructions for the Coumadin: the Coumadin is set up in the daily medication box. R6's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup for R6's Coumadin. On November 29, 2022, at 2:50 p.m., LPN-A stated she sets up R6's Coumadin every week on Tuesdays. LPN-A stated she does not document medication setup as there isn't a "spot" to document it anywhere. R5 R5's diagnoses included Parkinson's Disease (a	01770		

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01770	Continued From page 48	01770		

chronic progressive neurological disease which exhibits symptoms such as tremors, rigidity, impaired balance, slowness of movement and a shuffling gait), chronic kidney disease, chronic pain, and muscle weakness.

R5's service plan dated September 28, 2021, indicated the resident received medication management services.

R5's prescriber orders dated October 12, 2022, included an order for morphine (a moderate to severe controlled substance pain reliever) 2 mg to be administered inside the cheek three times a day and every one hour as needed for pain/dyspnea (difficult or labored breathing).

R5's nursing progress notes dated October 12, 2022, indicated orders had been received to start morphine 2 mg three times per day and every hour as needed for shortness of breath or pain.

R5's Individual Narcotic Record dated October 13, 2022, through October 21, 2022, indicated on October 13, 2022, 20 morphine sulfate 2 mg (0.1 cubic centimeter) syringes had been placed in the narcotic lock box by LPN-A.

R5's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup for R5's morphine sulfate.

On November 29, 2022, at 2:58 p.m., LPN-A stated she had drawn up 20 - 2 mg (0.1 cc) morphine syringes for R5 on October 13, 2022; and put them in bundles of five and had placed them in the narcotic box in the "RA" [service

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01770	Continued From page 49 room] room. LPN-A stated she had not documented this medication setup for R5's morphine. The licensee's Medication Administration System - Dosage Box Set-Up policy dated May 2015, noted when the registered nurse (RN) or LPN has completed setting up the medications into the Dosage Box, the nurse will document each individual medication that has been set up on the MAR. Medications that cannot be set up in the dosage box (topical or liquid) will be recorded on the MAR to include any special instructions and the MAR will include medication name and strength, storage, dosage to be administered, day and time of administration, route of administration, drug classification and special precautions, and any special instructions for administering the medication to the client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature and stock medication was stored	01880		

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01880	Continued From page 50 according to manufacturer's recommended temperature. 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: On November 28, 2022, at 11:26 a.m., the surveyor toured the facility with licensed practical nurse (LPN)-A, including a review of the medication refrigerator in the locked service room. LPN-A stated the current temperature of the medication refrigerator was 34 degrees Fahrenheit (F). LPN-A stated she usually checks the refrigerator temperature whenever she works. LPN-A stated she looks to make sure the temperature is between the "blue marking" on the thermometer [32-42 degrees F]. The surveyor asked for the November medication refrigerator temperature log. LPN-A stated, "I don't have a log and I suppose I should". The refrigerator contained the following medications: - four unopened Levemir 100 units/milliliter (ml) insulin syringes for R3 - five unopened Basaglar 100 units/ml insulin syringes for R4 - one opened box containing 22 acetaminophen (mild pain reliever) 650 milligrams (mg) suppositories On November 28, 2022, at 11:28 a.m., the	01880		

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01880	Continued From page 51 surveyor reviewed the storage instructions on the box of acetaminophen suppositories with LPN-A. The instructions indicated the suppositories should be stored at 68-77 degrees F. LPN-A stated, "they shouldn't be in the refrigerator". The manufacturer's instructions for Levemir insulin pens dated January 2019 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). The manufacturer's instructions for Basaglar insulin pens dated September 2021 indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Basaglar to freeze. The licensee's Storage of Medications policy dated August 1, 2021, noted medications would be handled and stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01890		

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	26536	A. BUILDING: _____ B. WING _____	11/30/2022

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01890	Continued From page 52 review, the licensee failed to monitor for expired stock medications and failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of two 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) 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: EXPIRED MEDICATION On November 28, 2022, at 11:26 a.m., the surveyor toured the facility with licensed practical nurse (LPN)-A, including a review of the stock medication cupboard in the service room. The following medication was found to be expired: - one opened bottle of acetaminophen (mild pain reliever) 325 milligrams expired August 2022 On November 28, 2022, at 11:32 a.m., LPN-A stated "I'll remove it from the cupboard as it expired in August." LPN-A was unaware if the facility had a process for checking for outdated medications. TIME SENSATIVE MEDICATIONS On November 29, 2022, at 7:20 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R4's scheduled morning dose of Basaglar 16 units of insulin. R4's Basaglar 100 units/milliliter (ml) insulin syringe did not have a label which indicated the date the insulin pen had	01890		

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01890	Continued From page 53 been put into use. ULP-G stated R4's Basaglar insulin pen did not have a date written on it when it was opened, and it should have been dated. On November 29, 2022, at 9:06 a.m., registered nurse (RN)-C stated all insulin pens should be dated with a date when opened. The manufacturer's instructions for Basaglar insulin pens dated September 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The licensee's Storage of Medications policy dated August 1, 2021, noted a prescription drug must be kept in its original container bearing the original prescription label with legible information including an expiration date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 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	01910		

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01910	Continued From page 54 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 interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted for services on May 3, 2017, and was discharged on July 19, 2022. R1's diagnoses included hypertension (HTN-high blood pressure), chronic kidney disease, chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing), heart failure (a condition in which the heart's function as a pump is inadequate to meet the body's needs), and Meniere's disease (an inner ear disorder which	01910		

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01910	Continued From page 55 causes episodes of dizziness). R1's service plan dated June 29, 2022, indicated R1 received medication management services which included medication administration. R1's July 2022, Medication Administration Record (MAR) indicated R1 received the following scheduled medications: - clonazepam (sedative) 0.25 milligrams (mg) daily - carbidopa-levodopa (given to treat restless legs) 25-100 mg five times daily - Neomycin-Polymyxin B (antibiotic) 40-200,000 eye drop solution one drop administered in the right eye four times daily for seven days (July 9-15th) - ascorbic acid (vitamin) 500 mg daily - aspirin (given for heart protection) 81 mg daily - cyanocobalamin (vitamin) 100 micrograms (mcg) daily - Epoetin Alfa (given to treat anemia) 40,000 units/milliliter given every four weeks as needed - vitamin E 400 units daily - Ferrous Gluconate (iron supplement) 240 mg twice daily - Lasix (diuretic) 20 mg daily - gabapentin (anticonvulsant) 100 mg given daily - lisinopril (antihypertensive) 40 mg daily - Neptazane (glaucoma medication) 50 mg daily - multivitamin one tab daily - refresh tears (dry eye medication) one drop both eyes three times daily - vitamin B complex daily - Tylenol (minor pain reliever) extra strength 100 mg at bedtime R1's prescriber orders dated June 21, 2022, included all the above noted medications.	01910		

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01910	Continued From page 56 R1's nursing progress note dated July 19, 2022, and written by registered nurse (RN)-C indicated R1 had been discharged from services and moved to [name of a skilled nursing facility] at 10:45 a.m. on "7/129/22 [sic]" R1's Discharge Summary dated August 16, 2022, written by licensed practical nurse (LPN)-A indicated the prescribed and over the counter medications prior to discharge were "sent with her [R1]" and the prescribed and over the counter medications post discharge were "sent with her [R1] on discharge to the skilled [nursing facility]". R1's Medication Disposition/Disposal Record dated July 27, 2022, noted the following medications had been disposed of by RN-C and LPN-A in the Drug Buster (a medication disposal system): - 51 tablets of naproxen (anti-inflammatory) 220 mg - 3 ml's "Neo Poly" drops (no strength identified) - 40 Aleve (anti-inflammatory) tabs (no strength identified) - 59 Aleve "caps" (no strength identified) On November 28, 2022, at 3:16 p.m., RN-C stated all the medications R1 was taking at the time of her discharge were sent with her to the skilled nursing home. RN-C stated, "they took it [the medications] and it wasn't documented". RN-C stated the strength for the above noted Aleve and Neo Poly eye drops were not recorded on the Medication Disposition/Disposal Record because the form did not have a spot to document the strength of the medications disposed. The licensee's Disposition or Disposal of Medication policy dated August 1, 2021, noted	01910		

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01910	Continued From page 57 when a client's current medications that are secured or stored by our agency will be given to the client or the client's representative when the client's medication management services are terminated. Staff will document in the client's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01920 SS=D	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by:	01920		

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01920	Continued From page 58 Based on observation, interview and record review, the licensee failed to follow the procedure for loss and spillage of a controlled substance of a stock medication managed by the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 November 28, 2022, at 10:20 a.m., during the entrance conference consulting registered nurse (RN-D) stated all narcotic medication was double locked in a cabinet and counted by two staff members at the end/start of each shift. The staff members document this reconciliation in the narcotic book (a paper record which documents the removal and addition of the identified controlled substance) and if the count was off, they should contact the RN and the licensee's Loss and Spillage policy would be followed. On November 28, 2022, at 12:04 p.m., the locked medication cupboard in the nursing office was reviewed with LPN-A, RN-C, and consulting RN-D. LPN-A and consulting RN-D looked at the stock Hospice Emergency Supply bottle of morphine sulfate 100 milligrams/5 milliliters (mg/ml) which was placed on top of the nursing desk, and both visualized the side of the morphine bottle and stated the amount in the bottle was 26 ml. LPN-A stated the bottle of morphine sulfate had been opened. The	01920		

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01920	Continued From page 59 Individual Narcotic Record for the Hospice Emergency Supply morphine sulfate 100 mg/5 ml (page 79 of the bound narcotic book) was reviewed with LPN-A, RN-C, and consulting RN-D. LPN-A stated the last time the Hospice Emergency Supply bottle of morphine sulfate had been counted was on January 3, 2022, at 11:00 a.m., and was recorded as having a remaining amount of 30 ml. This entry had been signed by RN-C (no witness signature). LPN-A stated she did not have any other narcotic log counting form for this medication. At 12:10 p.m., LPN-A and RN-C stated they were unable to account for the missing 4 ml of morphine sulfate. On November 28, 2022, at 12:19 p.m., consulting RN-D pulled up the licensee's Controlled Substances/Scheduled II Drugs policy dated August 1, 2021, on her laptop and recited from the policy that "assisted living staff, including a licensed nurse whenever possible, will use a preferred practice of counting controlled drugs at the end of each shift if medications are stored securely outside of the resident's room. The staff person coming on duty and the staff person going off duty will count the controlled medications together and will document and report any discrepancies immediately to the RN." Consulting RN-D stated narcotics should be counted after each shift per the licensee's policy and the policy had not been followed. On November 28, 2022, at 12:30 p.m., RN-C stated to the surveyors that LPN-A had drawn up nine syringes of morphine sulfate for R5 out of the Hospice Emergency Supply on October 21, 2022, and not recorded it in the narcotic book. RN-C stated they had made the corrections in the narcotic book and all the morphine was accounted for. The surveyor requested from	01920		

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01920	Continued From page 60 RN-C the documentation of the above noted incident and investigation. A brief review of R5's record included the following: R5's service plan dated September 28, 2021, indicated the resident received medication management services to include medication administration. R5's medication management assessment dated July 28, 2022, noted R5's narcotic and scheduled medications were kept double locked in the service room and were signed out with two staff. The RN reviews the narcotic book with LPN to ensure all medications are accounted for monthly. R5's prescriber orders dated October 12, 2022, included an order for morphine (a moderate to severe controlled substance pain reliever) 2 mg to be administered inside the cheek three times a day and every one hour as needed for pain/dyspnea (difficult or labored breathing). R5's nursing progress notes dated October 17, 2022, at 8:09 a.m., written by LPN-A noted the writer [LPN-A] had received a phone call at 6:20 a.m., that R5 had passed peacefully. RN-C provided the revised narcotic logs for R5's morphine sulfate and the Hospice Emergency Supply morphine sulfate log. A review of the Individual Narcotic Record Hospice Emergency Supply for morphine sulfate 100 mg/5 ml's (page 79 of the bound narcotic book) indicated the following: - entry dated January 3, 2022, at 11:00 a.m., amount remaining - 30 ml; "counted" and signed by RN-C - entry dated November 28, 2022, (no time) noted	01920		

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01920	Continued From page 61 "see page 108 - drew up 9 doses of ½ cc [0.5 cubic centimeter which is equivalent to 0.5 ml which is equivalent to 10 mg of morphine] for [name of resident R5] October 21, 2022". [R5's order for morphine sulfate dated October 12, 2022, was for 2 mg (0.1 ml) to be administered three times daily and every one hour as needed]. - the next line it was documented the amount remaining was 25.5 ml left in bottle and co-signed by RN-C and LPN-A. A review of R5's Individual Narcotic Record [page 108] indicated under the name of the medication and dose "morphine" [no dosage listed] indicated on October 21, 2022, at 1:20 p.m., under the dose column "2 mg" [which is equivalent to 0.1 ml of the morphine concentration of 100 mg/5ml]; under the amount remaining column "9 syringes" and co-signed by LPN-A and RN-C. On the next line (no date or time or signature after the entry) it was noted "drawn up from stock bottle and transferred to RA [resident assistance] book" and documented under the amount remaining "0". As noted above R5 had passed away on October 17, 2022. A review of R5's Individual Narcotic Record in the service room [which is the RA book mentioned above] indicated under the name of the medication and dose "morphine sulfate" and the directions for use 2 mg (0.1 cc) three times per day and 2 mg (0.1 cc) as needed every hour. On October 13, 2022, 20 syringes were received; and 2 mg prefilled syringes were administered as ordered from October 13 - 16, 2022. The entry dated October 16, 2022, at 7:00 p.m., indicated there were 9 syringes of morphine remaining. The next entry was dated October 21, 2022, at 1:20 p.m. - the dose noted to be 2 mg and the amount remaining was "0" and this was signed by LPN-A.	01920		

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01920	Continued From page 62 The next line on this log had a line through the next row. The last documented line (no date or time) indicated "placed [illegible scribble] in main office lock box d/t [due to] resident expired" this entry was co-signed by LPN-A and RN-C. On November 29, 2022, from 2:53 p.m. to 3:16 p.m., the surveyor conducted an interview with LPN-A, RN-C, and consulting RN-D. At 2:53 p.m., consulting RN-D reviewed R5's morphine sulfate order and stated R5's order was for 2 mg of morphine to be given three times a day and every one hour as needed. At 2:54 p.m., RN-C and LPN-A reviewed R5's October 2022, medication administration record (MAR) and stated R5 had received a total of 12 doses with three additional doses marked as not given [indicated by a circle around the date/time/initial a scheduled dose was to be given]. However, there was no documentation of why these three doses had not been given. At 2:58 p.m., LPN-A stated she had drawn up 20 - 2 mg (0.1 cc) morphine syringes for R5 on October 13, 2022, and put them in bundles of five and had placed them in the narcotic box in the "RA" room. LPN-A stated she had not documented this medication setup for R5's morphine. In response to the entry dated November 28, 2022, in the above noted Hospice Emergency Supply narcotic book LPN-A stated she had not drawn up 9 syringes of morphine for R5, she had removed the 9 syringes that were in the narcotic box and put them in the nursing office narcotic box because the resident had expired. RN-C stated she had documented on November 28, 2022, in the Hospice Emergency Supply morphine narcotic log that 9 doses of ½ cc syringes had been drawn up [which would have been 10 mg of morphine per dose compared to R5's provider order that 2 mg (0.1 cc) should be administered] because that	01920		

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01920	Continued From page 63 "equaled the amount of morphine that was missing". RN-C stated, "I can't answer anymore of how many were drawn up at this point everything is confusing". At 3:07 p.m., RN-C stated the documentation she made yesterday (November 28, 2022) was "incorrect". At 3:12 p.m., RN-C stated at this time we cannot account for the 4 ml of morphine sulfate 100 mg/5ml (equivalent to 80 mg of morphine sulfate) that is missing from the Emergency Hospice Supply morphine bottle. On November 29, 2022, at 3:14 p.m., the surveyor asked for a copy of the incident report and investigation for the missing morphine. RN-C stated she had something partially "typed up" however, RN-C stated she would not provide the surveyor a copy. On November 29, 2022, at 3:16 p.m., consulting RN-D stated when a narcotic is unaccounted for this would be considered a reportable event and should be reported to the Minnesota Adult Abuse Reporting Center (MAARC) and stated an investigation does not have to be finished before a report is made to MAARC. RN-C stated they have up to 24 hours to report to MAARC. RN-C stated a report had not been submitted to MAARC. On November 30, 2022, at 8:39 a.m., licensed assisted living director (LALD)-B, RN-C and LPN-A reviewed their investigation for the above noted missing 4 ml (80 mg) of morphine. LALD-B read from her laptop stated that some of this 4 ml's had been drawn up for R5, there had been up to a 10% (2 ml) evaporation of the medication from the bottle and some of the medication had spilled into the bottle cap. LALD-B stated education had been completed with RN-C and	01920		

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01920	Continued From page 64 LPN-A and they have changed their practice with regards to having emergency supplies of morphine available. On November 30, 2022, at 8:44 a.m., the surveyor asked for a copy of the investigation, the incident report and MAARC report. LALD-A stated an incident or MAARC report had not been made. LALD-A stated we will do an incident report today. At the time of exit on November 30, 2022, at approximately 6:00 p.m., no investigation, incident report or MAARC report were provided to the surveyor. The licensee's Loss or Spillage or Medications, Including Controlled Medications dated August 1, 2021, noted lost or spilled medications would be appropriately documented and disposed of consistent with agency policy. When theft or diversion of prescribed medications is suspected, the loss will be investigated, and the appropriate authorities will be contacted. When a loss or spillage of any medication occurs, a notation must be made in the client's medical record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the loss or spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. If the loss or spillage is of a controlled medication, the notation about the loss or spillage must be signed by the person responsible and one witness. A medication error form must be completed, and the nurse notified so that the required medication can be replaced and administered to the client on a timely basis. The designated RN will review the medication error reports on a timely basis. The agency is required to take appropriate action under federal	01920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26536	A. BUILDING: _____ B. WING _____	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE COTTAGE ON 6TH	611 WEST 6TH STREET PARK RAPIDS, MN 56470

(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
01920	Continued From page 65 or state regulations for any lost or unaccounted prescription drugs when theft or diversion is suspected. If theft or diversion is suspected, documentation will include the investigation and findings. If theft or diversion of prescription drugs is suspected, it must be reported to local law enforcement and may require a report to the MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	02040		

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02040	Continued From page 66 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 residents). The findings include: A review of the Hazard Vulnerability Assessment showed global hazards such as fire, gas leaks, and epidemics but did not include hazards or safety risks identified on and around the property. During an interview on November 29, 2022, at 11:15 a.m., Maintenance (H) confirmed during an interview that the facility failed to include safety risks or hazards identified on and around the property in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable	02310		

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02310	Continued From page 67 health care and medical, or nursing standards with regards to safely storing oxygen. 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: On November 29, 2022, at 7:18 a.m., the surveyor observed in the "Manor" nursing office two tall oxygen cylinders stored under the open sink area. The two oxygen cylinders were positioned upright and directly on the floor. The two oxygen cylinders were not securely stored in a holder or a stand. Unlicensed personnel (ULP)-G stated they oxygen cylinders were used for emergencies and not securely stored in a stand. On November 29, 2022, at 9:07 a.m., the surveyor toured the "Manor" nursing office with registered nurse (RN)-C. RN-C stated all oxygen cylinders should be stored in a metal stand/holder. RN-C stated the two oxygen cylinders positioned under the sink in the "Manor" nursing office were not stored securely in a holder. RN-C stated, "I didn't even know they were there". The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is	02310		

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02310	Continued From page 68 storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	03000		

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03000	Continued From page 69 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an unaccounted narcotic loss from a stock medication. 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).	03000		

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03000	Continued From page 70 The findings include: On November 28, 2022, at 10:20 a.m., during the entrance conference consulting registered nurse (RN-D) stated all narcotic medication was double locked in a cabinet and counted by two staff members at the end/start of each shift. The staff members document this reconciliation in the narcotic book (a paper record which documents the removal and addition of the identified controlled substance) and if the count was off, they should contact the RN and the licensee's Loss and Spillage policy would be followed. On November 28, 2022, at 12:04 p.m., the locked medication cupboard in the nursing office was reviewed with LPN-A, RN-C, and consulting RN-D. LPN-A and consulting RN-D looked at the stock Hospice Emergency Supply bottle of morphine sulfate 100 milligrams/5 milliliters (mg/ml) which was placed on top of the nursing desk, and both visualized the side of the morphine bottle and stated the amount in the bottle was 26 ml. LPN-A stated the bottle of morphine sulfate had been opened. The Individual Narcotic Record for the Hospice Emergency Supply morphine sulfate 100 mg/5 ml (page 79 of the bound narcotic book) was reviewed with LPN-A, RN-C, and consulting RN-D. LPN-A stated the last time the Hospice Emergency Supply bottle of morphine sulfate had been counted was on January 3, 2022, at 11:00 a.m., and was recorded as having a remaining amount of 30 ml. This entry had been signed by RN-C (no witness signature). LPN-A stated she did not have any other narcotic log counting form for this medication. At 12:10 p.m., LPN-A and RN-C stated they were unable to account for the missing 4 ml of morphine sulfate. At 12:19 p.m., consulting RN-D pulled up the licensee's	03000		

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03000	Continued From page 71 Controlled Substances/Scheduled II Drugs policy dated August 1, 2021, on her laptop and recited from the policy that "assisted living staff, including a licensed nurse whenever possible, will use a preferred practice of counting controlled drugs at the end of each shift if medications are stored securely outside of the resident's room. The staff person coming on duty and the staff person going off duty will count the controlled medications together and will document and report any discrepancies immediately to the RN." Consulting RN-D stated narcotics should be counted after each shift per the licensee's policy and the policy had not been followed. On November 28, 2022, at 12:30 p.m., RN-C stated to the surveyors that LPN-A had drawn up nine syringes of morphine sulfate for R5 out of the Hospice Emergency Supply on October 21, 2022, and not recorded it in the narcotic book. RN-C stated they had made the corrections in the narcotic book and all the morphine was accounted for. The surveyor requested from RN-C the documentation of the above noted incident and investigation. A brief review of R5's record included the following: R5's service plan dated September 28, 2021, indicated the resident received medication management services to include medication administration. R5's medication management assessment dated July 28, 2022, noted R5's narcotic and scheduled medications were kept double locked in the service room and were signed out with two staff. The RN reviews the narcotic book with LPN to ensure all medications are accounted for monthly.	03000		

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03000	Continued From page 72 R5's prescriber orders dated October 12, 2022, included an order for morphine (a moderate to severe controlled substance pain reliever) 2 mg to be administered inside the cheek three times a day and every one hour as needed for pain/dyspnea (difficult or labored breathing). R5's nursing progress notes dated October 17, 2022, at 8:09 a.m., written by LPN-A noted the writer [LPN-A] had received a phone call at 6:20 a.m., that R5 had passed peacefully. RN-C provided the revised narcotic logs for R5's morphine sulfate and the Hospice Emergency Supply morphine sulfate log. A review of the Individual Narcotic Record Hospice Emergency Supply for morphine sulfate 100 mg/5 ml's (page 79 of the bound narcotic book) indicated the following: - entry dated January 3, 2022, at 11:00 a.m., amount remaining - 30 ml; "counted" and signed by RN-C - entry dated November 28, 2022, (no time) noted "see page 108 - drew up 9 doses of ½ cc [0.5 cubic centimeter which is equivalent to 0.5 ml which is equivalent to 10 mg of morphine] for [name of resident R5] October 21, 2022". [R5's order for morphine sulfate dated October 12, 2022, was for 2 mg (0.1 ml) to be administered three times daily and every one hour as needed]. - the next line it was documented the amount remaining was 25.5 ml left in bottle and co-signed by RN-C and LPN-A. A review of R5's Individual Narcotic Record [page 108] indicated under the name of the medication and dose "morphine" [no dosage listed] indicated on October 21, 2022, at 1:20 p.m., under the dose column "2 mg" [which is equivalent to 0.1 ml of the morphine concentration of 100 mg/5ml];	03000		

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03000	Continued From page 73	03000		

under the amount remaining column "9 syringes" and co-signed by LPN-A and RN-C. On the next line (no date or time or signature after the entry) it was noted "drawn up from stock bottle and transferred to RA [resident assistance] book" and documented under the amount remaining "0". As noted above R5 had passed away on October 17, 2022.

A review of R5's Individual Narcotic Record in the service room [which is the RA book mentioned above] indicated under the name of the medication and dose "morphine sulfate" and the directions for use 2 mg (0.1 cc) three times per day and 2 mg (0.1 cc) as needed every hour. On October 13, 2022, 20 syringes were received; and 2 mg prefilled syringes were administered as ordered from October 13 - 16, 2022. The entry dated October 16, 2022, at 7:00 p.m., indicated there were 9 syringes of morphine remaining. The next entry was dated October 21, 2022, at 1:20 p.m. - the dose noted to be 2 mg and the amount remaining was "0" and this was signed by LPN-A. The next line on this log had a line through the next row. The last documented line (no date or time) indicated "placed [illegible scribble] in main office lock box d/t [due to] resident expired" this entry was co-signed by LPN-A and RN-C.

On November 29, 2022, from 2:53 p.m. to 3:16 p.m., the surveyor conducted an interview with LPN-A, RN-C, and consulting RN-D. At 2:53 p.m., consulting RN-D reviewed R5's morphine sulfate order and stated R5's order was for 2 mg of morphine to be given three times a day and every one hour as needed. At 2:54 p.m., RN-C and LPN-A reviewed R5's October 2022, medication administration record (MAR) and stated R5 had received a total of 12 doses with three additional doses marked as not given [indicated by a circle

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03000	Continued From page 74	03000		

around the date/time/initial a scheduled dose was to be given]. However, there was no documentation of why these three doses had not been given. At 2:58 p.m., LPN-A stated she had drawn up 20 - 2 mg (0.1 cc) morphine syringes for R5 on October 13, 2022, and put them in bundles of five and had placed them in the narcotic box in the "RA" room. LPN-A stated she had not documented this medication setup for R5's morphine. In response to the entry dated November 28, 2022, in the above noted Hospice Emergency Supply narcotic book LPN-A stated she had not drawn up 9 syringes of morphine for R5, she had removed the 9 syringes that were in the narcotic box and put them in the nursing office narcotic box because the resident had expired. RN-C stated she had documented on November 28, 2022, in the Hospice Emergency Supply morphine narcotic log that 9 doses of ½ cc syringes had been drawn up [which would have been 10 mg of morphine per dose compared to R5's provider order that 2 mg (0.1 cc) should be administered] because that "equaled the amount of morphine that was missing". RN-C stated, "I can't answer anymore of how many were drawn up at this point everything is confusing". At 3:07 p.m., RN-C stated the documentation she made yesterday (November 28, 2022) was "incorrect". At 3:12 p.m., RN-C stated at this time we cannot account for the 4 ml of morphine sulfate 100 mg/5ml (equivalent to 80 mg of morphine sulfate) that is missing from the Emergency Hospice Supply morphine bottle.

On November 29, 2022, at 3:14 p.m., the surveyor asked for a copy of the incident report and investigation for the missing morphine. RN-C stated she had something partially "typed up" however, RN-C stated she would not provide the

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03000	Continued From page 75 surveyor a copy. On November 29, 2022, at 3:16 p.m., consulting RN-D stated when a narcotic is unaccounted for this would be considered a reportable event and should be reported to the Minnesota Adult Abuse Reporting Center (MAARC) and stated an investigation does not have to be finished before a report is made to MAARC. RN-C stated they have up to 24 hours to report to MAARC [as noted above the missing narcotic was discovered on November 28, 2022, at 12:10 p.m., putting this at 27 hours after the discovery of the missing 4 ml - 80 mg of morphine sulfate]. RN-C stated a report had not been submitted to MAARC. On November 30, 2022, at 8:44 a.m., LALD-A stated a MAARC report had not been made. The licensee's Abuse Prevention Plan policy dated March 2022, noted incidents are reported, documented, and investigated internally using [corporate name] incident reporting policy and procedure. Not all incidents need to be reported to an outside agency. Incidents where it is determined that maltreatment may be occurred must be reported to the appropriate state agency. All alleged incidents or maltreatment are reported to the state agency and to all other agencies as required and all necessary corrective actions, depending on the results of the investigation, are taken. "Immediately" means as soon as possible, but not more than 24 hours after discovery of the incident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

DEPARTMENT OF HEALTH

Type: Full
Date: *11/29/22*
Time: 15:27:47
Report: 1019221143

Food and Beverage Establishment Inspection Report

Location:
Heritage Manor
602 Fair Avenue
Park Rapids, MN56470
Hubbard County, 29

Establishment Info:
ID #: 0027598
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Heritage Manor

Phone #: 2182378345
ID #: 37043

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

OBSERVED ESTABLISHMENT DID NOT HAVE A WAY TO TEST THE SANITIZING TEMP OF THE HOT WATER DISH MACHINE

Comply By: 12/16/22

2-100 Supervision

2-102.12AMN

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

OBSERVED CFPM LICENSED PRESENTED AT TIME OF INSPECTION WAS EXPIRED.

Comply By: 01/30/23

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 F Degrees Fahrenheit - Location: KITCHEN FRIDGE
Violation Issued: No

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

AS DISCUSSED WITH HRD, THE HERITAGE MANOR KITCHEN IS TO BE INSPECTED WHILE ONSITE.
HERITAGE MANOR KITCHEN IS A SERVING KITCHEN FOR FOOD PREPARED AT THE ATTACHED NURSING HOME.

Type: Full
Date: *11/29/22*
Time: 15:27:47
Report: 1019221143
Heritage Manor

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1019221143 of 11/29/22.

Certified Food Protection Manager: BARBARA OLSON

Certification Number: FM 40697 Expires: 08/12/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
BARBARA OLSON
FOOD SERVICE DIRECTOR

Signed: _____
Jared Morrill
Sanitarian
Bemidji
218 308-2128