Electronically Delivered

June 8, 2023

Licensee
Northern Lakes Senior Living
8186 Excelsior Road
Baxter, MN 56425

RE: Project Number(s) SL31987015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 17, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

the specific statute(s).

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

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31987	A. BUILDING: _____ B. WING _____	05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN LAKES SENIOR LIVING	8186 EXCELSIOR ROAD BAXTER, MN 56425

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0 000	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: SL31987015 On May 15, 2023, through May 17, 2023, 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 65 active residents; all receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 15, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in	0 510		

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0 510	Continued From page 2 assisted living facilities. (c) 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 ensure infection control standards were followed for two of two unlicensed personnel (ULP-C, ULP-F) during personal cares for R1. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On May 16, 2023, at 10:27 a.m., the surveyor observed ULP-C and ULP-F enter R1's room and don a pair of gloves. ULP-C and ULP-F lowered R1's pants, partially removed R1's brief and provided incontinence care. ULP-F gathered a clean wash cloth, a basin of clean water and assisted ULP-C to complete incontinence cares. ULP-F assisted ULP-C in rolling R1 from the left side to the right side and back for the removal of the soiled brief and cleaning R1's bottom. ULP-C used a clean wet wash cloth to wash R1's facial area and arms while waiting for ULP-F to attain the barrier cream for R1's bottom. With the same gloved hands, ULP-C provided peri-care, applied barrier cream to R1's bottom and washed R1's face. ULP-C and ULP-F completed putting a clean brief on R1 and dressed R1 in clean clothes	0 510		

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0 510	Continued From page 3	0 510		

attained from R1's closet and used a mechanical lift to transfer R1 from the bed to R1's wheelchair. ULP-F fluffed R1's pillow and pulled the blankets up to make R1's bed. ULP-C and ULP-F removed the soiled gloves after all tasks were completed, donned a new pair of gloves (did not perform hand hygiene after removing gloves) and provided ambulation assistance to R1 via the manual wheelchair from his room to a weigh in area at the end of the hallway.

The surveyor did not observe ULP-C or ULP-F remove their gloves and perform hand hygiene following incontinence cares.

On May 16, 2023, at 11:00 a.m., directly following the above observation, ULP-C stated she had not changed her gloves or performed hand hygiene after she had provided incontinence care and prior to applying the barrier cream to R1's bottom. ULP-C stated, "I should have done that, we are taught to wash between". ULP-C stated she was aware hand hygiene should be done each time gloves were removed.

On May 16, 2023, at 11:05 a.m., directly following the above observation, ULP-F stated she carried clean gloves and hand sanitizer in her pocket. ULP-F stated she used hand sanitizer prior to entering a resident's room and donning gloves and uses the hand sanitizer when she leaves a resident's room. ULP-F stated, "I sanitize between rooms, that's how I do it."

On May 16, 2023, at 3:42 p.m., clinical nurse supervisor (CNS)-B stated her expectations were for staff to change gloves and perform hand hygiene after providing incontinence cares. "It is definitely taught to use hand sanitizer or soap and water if you are moving between peri-care to

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0 510	Continued From page 4 other tasks." The licensee's Standard Infection Control Precautions policy dated August 1, 2022, noted hands should be washed after removing gloves, between tasks and procedures on the same client to prevent cross-contamination of different body sites and gloves were to be promptly removed after use and before touching non-contaminated items, environmental surfaces. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780		

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0 780	Continued From page 5 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide interconnected smoke alarms in a resident room. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: On a facility tour on May 16, 2023, at approximately 11:30 p.m. with environmental services director (ESD)-F it was observed that multiple smoke detectors were installed in resident room 112, but activation of one alarm did not activate all alarms in the resident room. Smoke alarms are required to be interconnected in resident rooms so that activation of one alarm activates all alarms in the individual resident room. This deficient finding was visually verified by ESD-F at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7)	0 780		

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0 780	Continued From page 6 days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on May 16, 2023, at approximately 12:00 p.m. with environmental services director (ESD)-F it was observed that the exhaust fan was not operating in the Salon. The exhaust fan is required to operate as designed	0 800		

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0 800	Continued From page 7 and installed at the time of construction approval. A glycol leak from a filter valve on the heating supply line of the building space heating boiler in the boiler room was observed, creating a puddle on the floor. A missing ceiling tile in the employee break room was observed on the facility tour. The ceiling tile is required to be maintained as designed and installed at the time of construction approval. These deficient conditions were visually verified by ESD-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 8 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review of available documentation and interview were conducted on May 16, 2023, at approximately 10:15 a.m. of documents provided by licensed assisted living director (LALD)-A and environmental services director (ESD)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the	0 810		

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0 810	Continued From page 9 facility. Findings include: Record review of the available documentation indicated that the licensee did not provide number of resident rooms on the fire safety and evacuation floor plan. Resident room numbers are required to be included on the fire safety and evacuation floor plan for more accurate reference and communication of direction for evacuation. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. At the time of the interview training materials were verbally presented by LALD-A and it was stated that the training was completed but written documentation was not available. Record review of the available documentation indicated that the licensee did not offer training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Written documentation of training of residents in regard to actions required for evacuation is required to be offered once a year. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. During the interview LALD-A provided documentation that drills had been completed but not in the required sequence of twice per shift per year and at least every other month. All deficiencies were verified by LALD-A and	0 810		

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0 810	Continued From page 10 ESD-F during the interview at approximately 11:15 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed an ongoing reassessment and	01620		

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01620	Continued From page 11	01620		

monitoring on or before day 90 for one of three residents (R3).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On May 15, 2023, at 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated a registered nurse completed assessments pre-admission, initial assessment, at 14 days, every 90 days, and with changes in condition.

R3 began receiving services on July 20, 2021.

R3's record included a 90-day comprehensive assessment dated July 29, 2022, and a 90 day comprehensive assessment dated March 21, 2023, 146 days after the 90 day assessment was due.

On May 16, 2023, at 3:45 p.m., clinical nurse supervisor (CNS)-B stated she was aware of the requirement to have nursing assessments completed at least every 90-days. CNS-B further stated they have had a lot of nursing staff turnover and the assessments got missed.

The licensee's Assessment of Clients- Initial and Ongoing policy revised August 1, 2021, and last

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 12 reviewed May 23, 2022, indicated the nurse will re-assess and monitor each client on an on-going basis and will revise the client's service plan based on the client's needs. The RN will determine the frequency between assessments no more than 14 days after initiation of care and thereafter not to exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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	31987	A. BUILDING: _____ B. WING _____	05/17/2023

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01640	Continued From page 13 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee or resident to document agreement on the services to be provided for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's signed Service Plan dated March 11, 2022, included services of blood glucose checks, 90-day monitoring visits, COVID-19 screenings, showers, meal tray delivery, laundry, medication management, and safety checks. The total payor cost was $2,970.00. R3's unsigned Service Plan with print date of May 15, 2023, included services of diabetic management, transportation assistance, bathing, meal tray delivery, dressing, nail care, 90-day assessment, bed making, housekeeping, linen laundry, laundry, medication administration, blood glucose assistance, and safety checks. The total payor cost was $4,385.00. R3's record lacked a current service plan with	01640		

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01640	Continued From page 14 signature or authentication by the resident or resident's representative with all current services provided by licensee after addition of services on or after March 11, 2022. On March 16, 2023, at 3:45 p.m., clinical nurse supervisor (CNS)-B stated every time there is a change in services for a resident a new service agreement should be signed. The nurse completing the assessment was responsible for this. The licensee's Service Plan Agreement Development and Revision policy revised August 1, 2021, indicated if a review of the service plan indicates that the client's service plan agreement needs modification based on the client's needs, preferences or changes in fees, the RN: makes necessary changes to the service plan signs the revised service plan with name, title, and date requests that the client and/or the client's representative sign and date the revised service plan files the signed service plan in the client record No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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01760	Continued From page 15 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one unlicensed personnel (ULP)-D observed administering medications. 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-D was hired on January 13, 2020, to provide direct care services to the licensee's residents. ULP-D was trained and competency tested on medication administration on January 15, 2020, by a registered nurse (RN). On May 16, 2023, at 7:50 a.m., the surveyor observed ULP-D conduct a medication pass for R7 and the following was observed:	01760		

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01760	Continued From page 16 - ULP-D opened R7's electronic MAR (medication administration record), verified each medication and placed into a small medication cup; - ULP-D entered R7's room, attained a cup of water and handed the medication cup and water to R7; - R7 swallowed all medications with the exception of one tablet that had fallen on the floor; - ULP-D picked the tablet up from the floor and placed it back into the medication cup; - ULP-D exited the room, went back to the medication cart, placed the tablet into a medication destruction envelope and wrote the residents name, medication, date and time on the envelope; and - ULP-D put the envelope in the medication cart and documented the medication as "held" to complete the medication pass. ULP-D did not contact nursing and did not offer a new tablet to R7 as a replacement for the medication that dropped on the floor. On May 16, 2023, at 8:05 a.m., the surveyor asked what the process was if a medication tablet dropped on the floor. ULP-D stated, "I'll give that envelope to a nurse today and she [R7] just won't get that med today, otherwise, it messes up the monthly cycle of medications". On May 16, 2023, at 3:42 p.m., clinical nurse supervisor (CNS)-B stated staff should have contacted a nurse and a nurse would have instructed the staff to administer a replacement tablet. The licensee's Medication Documentation on the Resident Medication Administration Record policy dated August 1, 2021, noted if medication is dropped or soiled, staff were to contact the nurse	01760		

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01760	Continued From page 17 for instructions or directions for replacing the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of three residents (R7) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 15, 2023, at approximately 10:30 a.m., licensed assisted living director (LALD)-A and clinical nurse	01820		

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01820	Continued From page 18	01820		

supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility.

R7's diagnosis included dementia.

R7's Assessment dated May 10, 2023, indicated R7 required medication management services to include administration by facility staff, ordering and storage of medications and monitoring by facility nursing.

R7's medication administration record for April 2023, indicated R7 received the following medications: acetaminophen 650 mg (milligram); aspirin 81 mg; calcium 600 mg; vitamin D3 50 micrograms (mcg); Refresh eyedrops and Sterilid eyelid cleaner.

R7's record contained prescriber orders for admission dated November 14, 2022, however, the orders did not include prescription orders for R7's medications.

On May 16, 2023, at approximately 11:40 a.m., the surveyor requested signed prescriber orders for R7's medications. CNS-B stated the facility did not have prescription orders for R7 and "I am working on that now". Additionally, CNS-B stated it was the responsibility of all registered nurses (RNs) in the building, however, currently there was not a system in place to monitor that.

The licensee's Medication Management Services policy dated August 1, 2021, indicated the registered nurse is responsible for assuring that current, authorized prescriber orders for medications administered by staff are kept on file in the resident's records. Additionally, the licensee would require a prescription for all

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01820	Continued From page 19 scheduled and as needed medications that the licensee manage for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=E	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 review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for three of three residents (R1, R6, 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01890		

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01890	Continued From page 20 On May 16, 2023, at 7:30 a.m., the surveyor reviewed the locked medication carts with unlicensed personnel (ULP)-C. ULP-C observed and confirmed the following: R1 R1's opened Ketorolac 0.5% ophthalmic eye solution did not have a label which indicated when the solution had been opened and when the solution would expire. R6 R6's opened Ellipta 200 microgram (mcg)/62.5 mcg inhaler did not have a label which indicated when the inhaler had been opened and when the inhaler would expire. R7 R7's opened Refresh eyedrops did not have a label which indicated when the eyedrops had been opened and when the eyedrops would expire. On May 16, 2023, at approximately 8:00 a.m., ULP-C acknowledged the time sensitive medications were not labeled and stated "many emails have been sent out about this, I just don't think everybody is doing it." On May 16, 2023, at 4:10 p.m., clinical nurse supervisor (CNS)-B stated all medications should be labeled with an opened and expiration date. The manufacturer's instructions for Ketorolac eyedrops dated May 10, 2019, directed to discard 28 days after opening. The manufacturer's instructions for Ellipta dated August 2020, directed to write "tray opened" and "discard" dates on the inhaler label. The "discard"	01890		

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01890	Continued From page 21 date was six (6) weeks from the date opened. The manufacturer's instructions for Refresh eyedrops dated September 2016, directed not to use the product more than 30 days after first opening. The licensee's Storage of Medications policy dated April 19, 2023, did not address labeling time sensitive medications with the open or expiration date. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *05/15/23*
Time: 11:30:00
Report: 6808231121

Food and Beverage Establishment Inspection Report

Location:
Northern Lakes Senior Living
8186 Excelsior Road
Baxter, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0031834
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
TM Excelsior LLC

Phone #: 2184542121
ID #: 43981

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.

5-200C Plumbing: Maintenance, fixture location
5-205.11AB ***** Priority 2 *****
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
DO NOT STORE THE GARBAGE CAN IN FRONT OF THE HAND SINK IN THE MEMORY CARE KITCHEN.
Comply By: 05/15/23

Surface and Equipment Sanitizers

Hot Water: = at 171 Degrees Fahrenheit
Location: FINAL RINSE TEMPERATURE IN DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Prep Cooler
Temperature: 40 Degrees Fahrenheit - Location: TOMATOES IN TOP & BOTTOM
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: VEGETABLE BASE IN UNDERCOUNTER UNIT
Violation Issued: No

Process/Item: Steam Table
Temperature: 158 Degrees Fahrenheit - Location: RIBS
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 40/41 Degrees Fahrenheit - Location: BEEF/MEATBALLS
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: PINEAPPLE IN ADVANT EDGE UNIT
Violation Issued: No

Process/Item: Hot Holding
Temperature: 159 Degrees Fahrenheit - Location: SOUP IN WARMER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: MILK IN SERVICE AREA
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: PINEAPPLE IN MEMORY CARE UNIT
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 6808231121 of 05/15/23.

Certified Food Protection Manager: Lisa Battin

Certification Number: _____ Expires: 06/02/25

Signed: _____
Establishment Representative

Signed: Lee Ann Austin
Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us