



Protecting, Maintaining and Improving the Health of All Minnesotans

November 3, 2023

Licensee
Cornerstone Care, LLC
23766 570th Avenue
Litchfield, MN 55355

RE: Project Number(s) SL33450015

Dear Licensee:

On October 18, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 23, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kelly Thorson'.

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 25, 2023

Licensee
Cornerstone Care LLC
23766 570th Avenue
Litchfield, MN 55355

RE: Project Number(s) SL33450015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 23, 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 . . ."

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH may impose 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 MDH 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 (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 survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

REQUESTING A HEARING

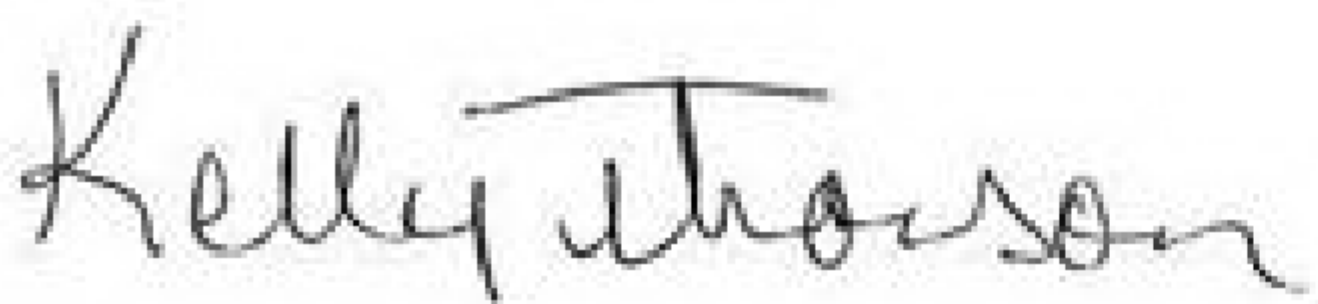
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33450	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/23/2023
NAME OF PROVIDER OR SUPPLIER CORNERSTONE CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 23766 570TH AVENUE LITCHFIELD, MN 55355		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION 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: SL33450015-0 On August 21, 2023, through August 23, 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 four residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed and posted, potentially affecting the licensee's four (4) current residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 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: The licensee held an assisted living facility license. The facility was licensed for a bed capacity of four residents and had a current census of four residents. During the entrance conference on August 21, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the staffing schedule was the same everyday, and included two unlicensed personnel (ULP) from 6:30 a.m. to 2:30 p.m., Monday through Friday, and one ULP during that time on Saturday and Sunday. CNS/LALD-A stated one ULP was scheduled from 2:30 p.m. to 10:30 p.m., and one ULP from 10:30 p.m. to 6:30 a.m., and on weekends, if there was an event planned, a ULP would work from 11:00 a.m., to 8:00 p.m., to help out. STAFF POSTING During a tour of the facility with CNS/LALD-A on August 21, 2023, at 12:29 p.m., the surveyor observed postings in the main entry area, the common areas, and the medication room; however, these areas lacked the required posting of the daily staff schedule. The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident	0 470			

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0 470	Continued From page 3 assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On August 22, 2023, at 8:45 a.m., CNS/LALD-A stated a monthly schedule was posted on a cupboard above the housing manager's desk; however, the daily staffing schedule was not posted in a central location, as required. STAFFING PLAN The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On August 21, 2023, at 10:18 a.m., CNS/LALD-A provided the licensee's Conventional Staff Plan to Fill Staffing Gaps and Contingency and Crisis Staffing information from the Emergency Preparedness Planning binder which included directions to seek additional staff when needed in an emergency; however, CNS/LALD-A stated she had no evidence of an evaluation for the appropriateness of the staffing levels in the facility and stated the staffing plan hadn't been reviewed "for a couple years."	0 470			

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0 470	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
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: (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 August 21, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			

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0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all four of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 485			

Minnesota Department of Health

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0 485	Continued From page 6 On August 21, 2023, at 3:18 p.m., the surveyor observed a menu on the bulletin board in the kitchen, dated August 21, 2023, to August 27, 2023, with breakfast, lunch, and supper meals, and alternatives listed. No other menus were observed. On August 21, 2023, at 3:20 p.m., unlicensed personnel (ULP)-B provided the menus that were posted to the surveyor, and stated she prepared the menus typically on Wednesdays, for the following week. ULP-B stated the menu was not available or provided to residents at least one week in advance, and stated the process needed improvement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 510 SS=F	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 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 510			

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0 510	Continued From page 7 by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one employee (unlicensed personnel (ULP)-B) observed to provide personal cares. 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 August 21, 2023, at 2:13 p.m., the surveyor observed ULP-B while providing personal cares for R2. ULP-B put on gloves, and announced to R2 that she was going to check his brief. ULP-B turned R2 slightly to the left side and pulled the brief away from R2's buttocks to look at the inside of the brief. ULP-B stated, "You're just wet," and proceeded to release the adhesive tabs on each side of the brief. With the same gloves on, ULP-B stepped away from the bedside, gathered a clean brief and washcloths, and went into R2's bathroom to put water on the washcloths. ULP-B returned to R2's bedside, pulled the wet brief out from under R2, touching the inside of the brief that was against R2's private area, and tossed the brief into the trash. ULP-B grabbed the clean brief and slid it under R2's bottom, used a washcloth to clean R2's private area, and tossed the washcloth into a basket. Without removing the gloves, ULP-B reached for a tube of ointment	0 510			

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0 510	Continued From page 8 in a basket hanging from the closet door, unscrewed the cap, squeezed ointment onto her fingers, and applied the ointment to R2's private area. ULP-B wiped the ointment from her fingers onto the inside of R2's brief, placed the brief into position, and secured the adhesive tabs on each side of the brief. Without removing the gloves, ULP-B removed R2's trapeze bar from the frame of the hospital bed and handed it to R2, directing R2 to lift buttocks off the bed so she could pull up the pants. Without removing the gloves, ULP-B positioned a pillow under R2's knees, covered R2 with the blanket, touched the bed to move the it away from the wall to straighten the bed linens, picked up the remote to adjust the hospital bed, pushed the bedside table closer so R2 could reach it, removed the plastic bag from the trash, and put in a new bag. ULP-B removed the gloves and threw them into the trash, and without performing hand hygiene, ULP-B picked up the trash bag, and stated she needed to make sure R2's two cell phones were plugged in and charging. ULP-B picked up each phone, ensured they were charging, and without performing hand hygiene, touched the door handle and opened R2's room door. Once outside the room, ULP-B used hand sanitizer to clean her hands, while carrying the plastic trash bag out to the garage to dispose. On August 21, 2023, at 2:23 p.m., ULP-B stated the hand sanitizer was located outside of R2's room, but stated she should have performed hand hygiene after removing her gloves and before touching items in the room. During an interview on August 21, 2023, at 2:40 p.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated hand hygiene should always be performed when	0 510			

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0 510	Continued From page 9 removing gloves. The licensee's Hand Washing policy, undated, indicated use of gloves does not replace handwashing, and hands should be washed or decontaminated after removing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content.	0 550			

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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
0 550	Continued From page 10 This had the potential to affect the licensee's four (4) current 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 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: The licensee lacked a posting of the grievance procedure to include the name, telephone number and e-mail contact information for the individuals who are responsible for handling resident grievances. During a tour of the facility on August 21, 2023, at 12:29 p.m., with clinical nurse supervisor (CNS/licensed assisted living director (LALD))-A, the surveyor observed the Complaint and Investigation Policy posted on a bulletin board in the common area. On August 21, 2023, at 12:35 p.m., CNS/LALD-A stated the required content noted above was not included. The licensee's Complaint and Investigation policy dated August 1, 2021, directed the resident to deliver a grievance to the RN (registered nurse) or any other staff they were comfortable with, and the RN would begin the investigation process within 24 hours and explore issues of the grievance; however, lacked the name, telephone number, and email contact information for the	0 550			

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0 550	Continued From page 11 individual who was responsible for handling resident grievances, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record	0 650			

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0 650	Continued From page 12 contained the required content for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D had a start date of May 8, 2023. Review of ULP-D's employee record included a Competency assessment skills checklist, dated May 15, 2023, with initials identified as ULP-B, which indicated ULP-B had provided practical skills testing for ULP-D; however, the second page was blank and lacked the registered nurse signature. ULP-D's record lacked evidence of the following: - records of competency evaluations. During an interview on August 23, 2023, at 9:50 a.m., ULP-D stated she performs all services during her shift, including treatments and medication administration. ULP-D stated she completed all of the licensee's required training prior to working with residents and observed ULP-B providing cares to the residents. ULP-D stated she had worked in previous facilities and had been trained to give medications, and when she came to this facility, she received training from clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A and	0 650			

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0 650	Continued From page 13 CNS/LALD-A observed her "to make sure I was doing it right." On August 23, 2023, at 9:55 a.m., ULP-B stated, all new employees were trained and observed by CNS/LALD-A prior to providing services by themselves. ULP-B stated CNS/LALD-A was "very strict about that." During a telephone interview on August 23, 2023, at 12:20 p.m., CNS/LALD-A stated her process was to train and ensure compliance of ULPs prior to working independently with residents, and she had definitely observed ULP-D while providing services to the residents, including medication administration. CNS/LALD-A stated she did not realize that she had not signed ULP-D's compliance form. The licensee's Orientation, Training, and Competency Evaluation of Staff Policy, undated, indicated training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse; however, the policy lacked direction to retain evidence of the completed training in the employees' records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660			

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0 660	Continued From page 14 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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH), which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for two of four employees (unlicensed personnel (ULP-C, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 660			

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0 660	Continued From page 15 The licensee's Facility TB (tuberculosis) Risk Assessment Worksheet for Health Care Settings Licensed by MDH (Minnesota Department of Health), reviewed October 1, 2022, indicated a low risk level. ULP-C ULP-C had a hire date of November 16, 2021. ULP-C's employee record contained evidence of one negative TST dated November 14, 2021; however, the record lacked evidence of a second TST, as required. In addition, ULP-C's record lacked evidence of a completed TB history and symptom screening. ULP-D ULP-D had a hire date of May 8, 2023. ULP-D's employee record contained a Baseline TB Screening Tool for Health Care Workers (HCWs), dated December 14, 2022, which included completed TB history and symptom screening, and evidence of administration of two TST, dated December 14, 2022, and December 28, 2022; however, the form lacked results of the two TST, and the TST were not dated within 90 days before hire, as required. The licensee's Tuberculosis Prevention: Control Plan and Risk Assessment policy, revised May 5, 2020, indicated the licensee would consistently follow all rules and recommendations of the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including screening all staff providing home care services, both paid and unpaid, at the time of hire for active TB disease and latent TB infection.	0 660			

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0 660	Continued From page 16 The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated each health care setting in Minnesota should have an up-to-date TB infection control program that included baseline TB screening consisting of three components: -assessing for current symptoms of active TB disease; -assessing TB history; and -testing for the presence of infection with mycobacterium tuberculosis by administering either a two-step TST or single IGRA (blood test to identify TB). Also included, an employee may begin working with patients after a negative TB symptom screen and a negative IGRA (Interferon Gamma Release Assay) or TST (first step) dated within 90 days before hire. The second TST may be performed after the employee starts working with patients. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680			

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0 680	Continued From page 17 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness (EP) plan with all of the required content defined in Appendix Z and failed to post an emergency preparedness plan prominently. In addition, the licensee lacked a missing resident plan with the required content and failed to evaluate/revise its plan at least quarterly. This had the potential to affect all four residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 680			

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0 680	Continued From page 18 The findings include: During the initial tour with clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A on August 21, 2023, at 10:40 a.m., the facility's layout included the main entrance from the garage. The main level included four resident rooms, the kitchen, dining room, living room, bathrooms, a medication administration room, and an office utilized by staff. There was no evidence of signage posted or information regarding the licensee's emergency plan, no emergency exit diagrams posted, and no evidence of emergency exit diagrams in each of the four residents' rooms, as required. On August 23, 2023, at 11:03 a.m., unlicensed personnel (ULP)-B provided a pink binder, located on a shelf in the office area, that contained undated Emergency Preparedness Planning. The binder included each resident's name, date of birth, and their emergency contact with phone numbers, a staff plan to fill staffing gaps, and contingency and crisis staffing, and types of emergencies that were covered in the Plan, including tornado, heat advisory, fire, bomb threat, loss of power, flood, landslide, nuclear explosion, active shooter, novel pandemic, and winter storm. During a telephone interview on August 23, 2023, at 12:20 p.m., CNS/LALD-A stated she was aware that the Emergency Preparedness Plan did not include the following required content: - a description of the population served by the licensee; - documentation of a missing resident plan that is reviewed quarterly;	0 680			

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0 680	Continued From page 19 - process for EP cooperation and collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan; - fire (not customized for the facility); - a tracking system used to document locations or residents and staff; - emergency staff strategies including surge planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			

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0 770	Continued From page 20	0 770			
0 770 SS=C	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide an inspected and approved septic system. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: On August 22, 2023, from approximately 1:05	0 770			

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0 770	Continued From page 21 p.m. to 1:30 p.m., survey staff toured the facility with Clinical Nurse Supervisor/Licensed Assisted Living Director (CNS/LALD)-A. During the facility tour, survey staff observed and verified the septic system was not in compliance with the county ordinance. CNS/LALD-A provided documentation from a local contractor for an estimate to install a new compliant septic system, but the work had not been performed at the time of survey. During interview, CNS/LALD-A stated they hope to have the new septic system installed and approved this Fall. No further information was given. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 770			
0 780 SS=F	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	0 780			

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0 780	Continued From page 22 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the provisions of the Minnesota State Fire Code and failed to provide smoke alarms that are interconnected throughout the facility so that actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all 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, 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). Findings include: On a facility tour on August 22, 2023, at approximately 1:15 p.m. with Certified Nurse Supervisor/Licensed Assisted Living Director (CNS/LALD)-A, observed that smoke alarms throughout the facility were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when the LALD/CNS-A tested the smoke alarms.	0 780			

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0 780	Continued From page 23 LALD/CNS-A verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide current tags and documentation of annual inspections of all the fire extinguishers and was unable to provide an adequately rated portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 790			

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0 790	Continued From page 24 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 August 22, 2023, at approximately 1:30 p.m. with Clinical Nurse Supervisor/Licensed Assisted Living Director (CNS/LALD)-A, it was observed that the fire extinguishers throughout the facility, did not have any current tags or documentation to indicate that annual inspections had been performed as required. CNS/LALD-A stated that the annual and monthly inspections were not being done. Annual inspections of the fire extinguishers are required by NFPA standards and Minnesota State Fire Code to ensure that all systems are maintained and remain in working order. It was also observed that each of the fire extinguishers provided were 1-A:10-BC rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. On August 22, 2023, at approximately 1:35 p.m., CNS/LALD-A verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810			

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0 810	Continued From page 25 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements. Also, failed to provide required employee training and drills on fire safety and evacuation as well as training to the residents who are capable. This had the potential to affect all staff, residents, and	0 810		

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0 810	Continued From page 26 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 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: An interview and record review were conducted on August 22, 2023, between approximately 1:45 p.m. and 2:00 p.m., with the Clinical Nurse Supervisor/Licensed Assisted Living Director (CNS/LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training and drills for the employees and residents of this facility. Record review indicated that the fire safety and evacuation plan did not have 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; employees did not receive training twice per year and after initial hire. Record review of the residents capable of self-evacuation were not provided training on proper actions to take in the event of a fire to include movement, evacuation, or relocation; and evacuation drills for employees had not been performed every other month as required. During interview, CNS/LALD-A stated that the facility recently let an employee go that had taken	0 810			

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0 810	Continued From page 27 all policies and procedures with them upon termination. CNS/LALD-A also stated that they did not have all these policies and procedures replaced at the time of survey. Policies were requested the fire safety and evacuation plan requirements, employee fire safety and evacuation training, resident training, and evacuation drills, but could not be provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide proper door locking arrangements that did not constitute a distinct hazard to life. This had the potential to directly affect all residents and staff.	0 820		

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0 820	Continued From page 28 This practice resulted in a level two 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 22, 2023, from approximately 12:45 p.m. to 1:30 p.m., survey staff toured the facility with Clinical Nurse Supervisor/Licensed Assisted Living Director (CNS/LALD)-A. During the facility tour, survey staff observed and verified front exit door had locking hardware that requires more than one operation to release and open. Exit door latch hardware is required to release, unlock, and open for the purpose of exiting in one operation. CNS/LALD-A verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: seven (7) days	0 820			
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and	0 930			

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0 930	Continued From page 29 conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R4). This had the potential to affect all residents residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's unsigned Service Plan, dated May 23, 2023, indicated R1 received services including fall prevention, bathing, grooming, toileting, medication management, glucose monitoring,	0 930			

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0 930	Continued From page 30 assistance with insulin administration, laundry, and housekeeping. R2's unsigned Service Plan, dated May 23, 2023, indicated R2 received services including full body transfers, fall prevention, meal assistance, exercises, bathing, dressing, grooming, incontinence care, seizure monitoring, medication management, behavior monitoring, laundry, and housekeeping. R4's unsigned Service Plan, dated June 6, 2023, indicated R4 received services including fall prevention, bathing reminders, toileting reminders, glucose monitoring, medication management, behavior monitoring, housekeeping and laundry. R1, R2 and R4's Assisted Living Facility Contract for Services and Housing, undated, signed by R1 on August 5, 2021, signed by R2 with no date, and signed by R4 on August 1, 2021, lacked the following required content: -the right under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which a resident consent is required for a transfer; and -contact information for the Ombudsman for Mental Health and Developmental Disabilities. On August 22, 2023, at 11:40 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the contract was developed by the licensee and stated she was unaware of the required contents. CNS/LALD-A stated all residents were given the same contract.	0 930			

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0 930	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930			
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term	0 940			

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0 940	Continued From page 32 care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R4). This had the potential to affect all residents residing in the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's unsigned Service Plan, dated May 23, 2023, indicated R1 received services including fall prevention, bathing, grooming, toileting, medication management, glucose monitoring, assistance with insulin administration, laundry, and housekeeping. R2's unsigned Service Plan, dated May 23, 2023, indicated R2 received services including full body transfers, fall prevention, meal assistance, exercises, bathing, dressing, grooming, incontinence care, seizure monitoring, medication management, behavior monitoring, laundry, and housekeeping. R4's unsigned Service Plan, dated June 6, 2023,	0 940			

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0 940	Continued From page 33 indicated R4 received services including fall prevention, bathing reminders, toileting reminders, glucose monitoring, medication management, behavior monitoring, housekeeping and laundry. R1, R2 and R4's Assisted Living Facility Contract for Services and Housing, undated, signed by R1 on August 5, 2021, signed by R2 with no date, and signed by R4 on August 1, 2021, lacked the following required content: - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that residents may be eligible for assistance with rent through the housing support program; - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and - the contact information to obtain long-term care consulting services under section 256B.0911. On August 22, 2023, at 11:40 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the contract was developed by the licensee and stated she was unaware of the required contents. CNS/LALD-A stated all residents were given the same contract.	0 940			

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0 940	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01440 SS=E	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 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 a registered nurse (RN) conducted supervision of unlicensed staff performing delegated services as required,	01440		

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01440	Continued From page 35 for two of three employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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-B ULP-B was hired on March 31, 2023, as the licensee's housing manager and to provide direct care services to residents of the assisted living facility. On August 22, 2023, at 6:56 a.m., the surveyor observed while ULP-B assisted R4 to check his blood glucose level, and then dialed the insulin pen for R4 to self-administer. ULP-B administered R4's eye drops and handed R4 a medication cup with oral medications to swallow with water. ULP-B's record lacked evidence an RN conducted direct supervision of ULP-B within 30 days of performing delegated tasks. ULP-D ULP-D was hired on May 8, 2023, to provide direct care services to residents of the assisted living facility. On August 23, 2023, at 9:50 a.m., ULP-D stated	01440			

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01440	Continued From page 36 she received training by ULP-B and clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A when she started at the facility and had been observed by CNS/LALD-A while giving medications, to ensure she was doing it correctly. ULP-D's record lacked evidence an RN conducted direct supervision of ULP-D within 30 days of performing delegated tasks. On August 21, 2023, at 2:44 p.m., CNS/LALD-A stated she supervised all employees "right away," and stated "I don't wait 30 days." The licensee's Supervision of ULP policy, revised August 1, 2021, indicated direct supervision of staff performing delegated nursing and home care tasks must be provided within 30 days after the individual begins working for the licensee and thereafter as needed based on performance. Also included, the licensee would retain documentation of supervision activities in the personnel records or resident charts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias;	01560			

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01560	Continued From page 37 (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: When interviewed on August 22, 2023, at 8:16 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee provided services to residents with dementia and other related disorders, and stated she did not have a description of the dementia training program, the categories of employees	01560			

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01560	Continued From page 38 trained, the frequency of training, and the basic topics covered, in written or electronic form for consumers. CNS/LALD-A stated she was not aware of this requirement. The licensee's Required Education for Assisted Living policy, dated August 1, 2021, indicated the licensee shall provide to residents in written or electronic form, a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			
01620 SS=F	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	01620			

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01620	Continued From page 39 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 resident reassessment and monitoring no more than 14 calendar days after initiation of services for one of one resident (R2), and within 90 calendar days from the last date of the assessment using the uniform assessment tool as required, for three of three residents (R1, R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 August 21, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated resident assessments were completed upon admission and then every 90 days, or with changes. 14 DAY ASSESSMENT R2	01620			

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01620	Continued From page 40 R2 was admitted for services on February 14, 2022. R2's diagnoses included seizures, wounds, generalized weakness, and incontinence. R2's unsigned Service Plan, dated May 23, 2023, indicated R2 received services including full body transfers, fall prevention, meal assistance, exercises, bathing, dressing, grooming, incontinence care, seizure monitoring, medication management, behavior monitoring, laundry, and housekeeping. R2's record included a Skilled Nursing Initial Evaluation/Assessment, signed by clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A on February 14, 2022. R2's record lacked a reassessment and monitoring no more than 14 calendar days after initiation of services, as required. UNIFORM ASSESSMENT TOOL R1 R1's diagnoses included bilateral edema (swelling) of lower extremity, high blood pressure, cirrhosis (scarring) of the liver, liver cancer, and seizure disorder. R1's unsigned Service Plan, dated May 23, 2023, indicated R1 received services including fall prevention, bathing, grooming, toileting, medication management, glucose monitoring, assistance with insulin administration, laundry, and housekeeping. R1's record included a 90 Day Nursing Assessment, dated April 1, 2023, and June 6, 2023; however, the assessment did not include all of the elements on the uniform assessment	01620		

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01620	Continued From page 41 tool, as required. R2 R2's record included a 90 Day Nursing Assessment, dated March 20, 2023; however, the assessment did not include all of the elements on the uniform assessment tool, as required. In addition, R2's record included a 90 Day Nursing Assessment, dated June 6, 2023; however, the assessment included R2's name, date of birth, vitals, and indicated R2 was sometimes alert, and the rest of the assessment was blank. EXCEEDED 90 DAYS R4 R4's unsigned Service Plan, dated June 6, 2023, indicated R4 received services including fall prevention, bathing reminders, toileting reminders, glucose monitoring, medication management, behavior monitoring, housekeeping and laundry. R4's record included a 90 Day Nursing Assessment, dated January 14, 2023, and a Skilled Nursing Initial Evaluation/Assessment, dated April 29, 2023, or 105 days later, instead of not to exceed 90 calendar days from the date of the last review, as required. On August 21, 2023, at 3:11 p.m., CNS/LALD-A stated she had used different forms when completing the residents' assessments and wasn't aware that some of the assessments did not include all of the elements on the uniform assessment tool, as required, and stated a 14 day was not completed for R2, and R4's most recent assessment exceeded 90 calendar days from the date of the last review. The licensee's The Comprehensive Assessment	01620			

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01620	Continued From page 42 policy, revised August 1, 2021, incorrectly directed the RN would complete an assessment within 5 days after initiation of home care services. The policy indicated a reassessment must be conducted in the client's home no more than 14 days after initiation of services, and ongoing client monitoring and reassessment must be conducted, as needed based on changes in the needs of the client and cannot 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=F	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.	01640			

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01640	Continued From page 43 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided, for four of four residents (R1, R2, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1's Service Plan, dated May 23, 2023, indicated R1 received services including fall prevention, bathing, grooming, toileting, medication management, glucose monitoring, assistance with insulin administration, laundry, and housekeeping. R1's Service Plan was signed by clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A; however, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. R2's Service Plan, dated May 23, 2023, indicated R2 received services including full body transfers, fall prevention, meal assistance, exercises, bathing, dressing, grooming, incontinence care,	01640			

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01640	Continued From page 44 seizure monitoring, medication management, behavior monitoring, laundry, and housekeeping. R2's Service Plan was signed by CNS/LALD-A; however, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. R4's Service Plan, dated June 6, 2023, indicated R4 received services including fall prevention, bathing reminders, toileting reminders, glucose monitoring, medication management, behavior monitoring, housekeeping and laundry. R4's Service Plan was signed by CNS/LALD-A; however, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. R5's Service Plan, dated June 6, 2023, indicated R5 received services including safety monitoring, fall prevention, dressing and grooming reminders and monitoring, transportation, assistance with financial affairs, medication management, behavior monitoring, housekeeping and laundry. R5's Service Plan was signed by CNS/LALD-A; however, lacked a signature or other authentication by the resident documenting agreement on the services to be provided. On August 22, 2023, at 11:40 a.m., CNS/LALD-A stated R1, R2, R4, and R5's service plans lacked a signature by the resident and the facility, as required. CNS/LALD-A stated she was not aware that the resident needed to sign the service plan. The licensee's Service Plan Implementation and Revisions Policy, undated, indicated 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.	01640			

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01640	Continued From page 45 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650			

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01650	Continued From page 46 by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for four of four residents (R1, R2, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 R1's Service Plan, dated May 23, 2023, indicated R1 received services including fall prevention, bathing, grooming, toileting, medication management, glucose monitoring, assistance with insulin administration, laundry, and housekeeping. R2 R2's Service Plan, dated May 23, 2023, indicated R2 received services including full body transfers, fall prevention, meal assistance, exercises, bathing, dressing, grooming, incontinence care, seizure monitoring, medication management, behavior monitoring, laundry, and housekeeping. R4 R4's Service Plan, dated June 6, 2023, indicated R4 received services including fall prevention, bathing reminders, toileting reminders, glucose monitoring, medication management, behavior monitoring, housekeeping and laundry.	01650			

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01650	Continued From page 47 R5 R5's Service Plan, dated June 6, 2023, indicated R5 received services including safety monitoring, fall prevention, dressing and grooming reminders and monitoring, transportation, assistance with financial affairs, medication management, behavior monitoring, housekeeping and laundry. R1, R2 R4, and R5's service plans lacked the following required content: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On August 22, 2023, at 11:40 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the service plan lacked the required content and stated the same service plan was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to	01700		

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01700	Continued From page 48 providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01700			

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01700	Continued From page 49 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 August 21, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee provided medication management services to all of the licensee's residents. R2 was admitted for services February 14, 2022. R2's diagnoses included seizures, wounds, generalized weakness, and incontinence. R2's Service Plan, dated May 23, 2023, indicated R2 received services including full body transfers, fall prevention, meal assistance, exercises, bathing, dressing, grooming, incontinence care, seizure monitoring, medication management, behavior monitoring, laundry, and housekeeping. R2's record lacked signed current prescriber medication orders. R2's Medication Record, dated August 1, 2023, through August 31, 2023, listed medications including a mild pain reliever, a medication to lower cholesterol, two medications to treat enlarged prostate, two antiseizure medications, a medication to treat low thyroid levels, three supplements, a medication to decrease inflammation, an antidepressant, a medication to prevent organ transplant rejections, an antibiotic, an antipsychotic, and medication to prevent blood clots.	01700			

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01700	Continued From page 50 R2's Medication Reconciliation Form, dated February 14, 2022, listed R2's medications, including the dose, frequency, route, and the number of tablets received; however, did not include the above required content. R2's Evaluation of Resident's Ability to Self-Administer Medications, dated February 14, 2022, listed R2's medications and indicated R2 was totally dependent on others for medication management and medication administrations; however, did not include the above required content. R2's 90 Day Nursing Assessment, dated March 20, 2023, indicated R2 needed help preparing and administering medications, and staff were to give all medications; however, did not include the above required content. R2's record lacked evidence the RN had conducted a medication assessment to include: - indications for medications; - side effects; - contraindications; and - identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. On August 22, 2023, at 11:40 a.m., clinical nurse supervision (CNS)/licensed assisted living director (LALD)-A stated the forms and assessment she was currently using lacked the above required content.	01700			

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01700	Continued From page 51 The licensee's Assessment for Medication Management Program policy, undated, indicated prior to providing medication management services, the RN would complete a face-to-face assessment with the resident to determine what medication services would be provided, and would include the following: - identification of all medications, including over the counter and herbal/dietary supplements; - medication reconciliation including: - indication for medications; - effectiveness of drug therapy; - side effects; - immediate desired effects; - unusual and unexpected effects; - actual or potential drug interactions; - duplicate drug therapy; - non-adherence with drug therapy; - drug therapy currently associated with laboratory monitoring; - allergic reactions; - changes in condition that contraindicate continued administration of the medication; and - potential for diversion of medication by the resident or others with access to it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01710 SS=E	144G.71 Subd. 3 Individualized medication monitoring and reassessment The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a	01710			

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01710	Continued From page 52 minimum, annually. 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 a face-to-face medication management reassessment to include all required content for two of two residents (R1, R4) 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 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 August 21, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee provided medication management services to all of the licensee's residents. R1 R1's diagnoses included bilateral edema (swelling) of lower extremity, high blood pressure, cirrhosis (scarring) of the liver, liver cancer, and seizure disorder. R1's unsigned Service Plan, dated May 23, 2023, indicated R1 received services including	01710			

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01710	Continued From page 53 medication management, glucose monitoring, and assistance with insulin administration. R1's prescriber orders dated December 28, 2022, and March 23, 2023, included two inhalers to prevent shortness of breath, three antidepressants, medication to prevent heart attack or stroke, medication to treat high cholesterol, eye drops to treat glaucoma, two laxatives, medication to treat seizures, an antacid, two supplements, medication to decrease fluid retention, and an antiviral. R1's record indicated a review of the Medication Management Services had been completed on May 23, 2020. R1's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. R4 On August 22, 2023, at 6:56 a.m., the surveyor observed while unlicensed personnel (ULP)-B checked R4's blood sugar, prepared R4's insulin pen for R4 to self-administer, and administered eye drops and oral medications. R4's diagnoses included high blood pressure, diabetes, irritable bowel syndrome, obesity, low thyroid levels and hyperlipidemia (high concentration of fat in blood). R4's unsigned Service Plan, dated June 6, 2023, indicated R4 received services including fall prevention, bathing reminders, toileting reminders, glucose monitoring, medication	01710			

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01710	Continued From page 54 management, behavior monitoring, housekeeping and laundry. R4's prescriber orders dated July 14, 2023, included medication to treat high blood pressure, two oral medications and three injectable medications to treat diabetes, two medications to decrease cholesterol and triglycerides, medication to decrease fluid retention, medication to decrease stomach acid, two laxatives, medication to treat low thyroid level, antiseizure medication, antidepressant, antipsychotics, and an antihistamine to treat allergies. R4's record indicated a review of the Medication Management Services had been completed on July 30, 2020. R4's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion. On August 22, 2023, at 11:40 a.m., CNS/LALD-A stated an annual medication management reassessment had not been completed for R1 and R4, as required. CNS/LALD-A stated this was the same for all residents at the facility. The licensee's undated Assessment for Medication Management Program policy indicated medication management reassessment would occur with resident symptomology, problems or concerns that may be medication related, with new prescriptions, and annually. No further information was provided.	01710			

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01710	Continued From page 55	01710			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01730 SS=F	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 56 (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management plan prior to providing medication management services, and with the required content, for three of three residents (R1, R2, 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 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 August 21, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee provided medication management services to all of the licensee's residents. R1 R1's diagnoses included bilateral edema (swelling) of lower extremity, high blood pressure, cirrhosis (scarring) of the liver, liver cancer, and seizure disorder.	01730			

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01730	Continued From page 57 R1's unsigned Service Plan, dated May 23, 2023, indicated R1 received services including medication management, glucose monitoring, and assistance with insulin administration. R1's prescriber orders dated December 28, 2022, and March 23, 2023, included two inhalers to prevent shortness of breath, three antidepressants, medication to prevent heart attack or stroke, medication to treat high cholesterol, eye drops to treat glaucoma, two laxatives, medication to treat seizures, an antacid, two supplements, medication to decrease fluid retention, and an antiviral. R1's record indicated a review of the Medication Management Services had been completed on May 23, 2020. R2 R2's diagnoses included seizures, wounds, generalized weakness, and incontinence. R2's Service Plan, dated May 23, 2023, indicated R2 received services including medication management. R2's record lacked signed current prescriber medication orders. R2's Medication Record, dated August 1, 2023, through August 31, 2023, listed medications including a mild pain reliever, a medication to lower cholesterol, two medications to treat enlarged prostate, two antiseizure medications, a medication to treat low thyroid levels, three supplements, a medication to decrease inflammation, an antidepressant, a medication to prevent organ transplant rejections, an antibiotic,	01730			

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01730	Continued From page 58 an antipsychotic, and medication to prevent blood clots. R2's Medication Reconciliation Form, dated February 14, 2022, listed R2's medications, including the dose, frequency, route, and the number of tablets received. R2's Evaluation of Resident's Ability to Self-Administer Medications, dated February 14, 2022, listed R2's medications and indicated R2 was totally dependent on others for medication management and medication administration. R4 On August 22, 2023, at 6:56 a.m., the surveyor observed while unlicensed personnel (ULP)-B checked R4's blood sugar, prepared R4's insulin pen for R4 to self-administer, and administered eye drops and oral medications. R4's diagnoses included high blood pressure, diabetes, irritable bowel syndrome, obesity, low thyroid levels and hyperlipidemia (high concentration of fat in blood). R4's unsigned Service Plan, dated June 6, 2023, indicated R4 received services including fall prevention, bathing reminders, toileting reminders, glucose monitoring, medication management, behavior monitoring, housekeeping and laundry. R4's prescriber orders dated July 14, 2023, included medication to treat high blood pressure, two oral medications and three injectable medications to treat diabetes, two medications to decrease cholesterol and triglycerides, medication to decrease fluid retention, medication to decrease stomach acid, two laxatives,	01730			

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01730	Continued From page 59 medication to treat low thyroid level, antiseizure medication, antidepressant, antipsychotics, and an antihistamine to treat allergies. R4's record indicated a review of the Medication Management Services had been completed on July 30, 2020. R1, R2, and R4's records lacked a medication management plan to include the following required content: - a statement describing the medication management services that will be provided; - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - 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. On August 22, 2023, at 11:40 a.m., CNS/LALD-A stated R1, R2, and R3's records lacked a current individualized medication management plan with the above required content and stated this was the same for all residents at the facility.	01730		

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01730	Continued From page 60 The licensee's undated Assessment for Medication Management Program policy indicated based on the results of the medication management assessment, the clinician would document an individualized medication management plan, including the required contents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to manufacturer's guidelines and failed to verify accuracy of prescriber orders when transcribing orders for	01760			

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01760	Continued From page 61 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, 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 August 21, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee provided medication management services to all of the licensee's residents. R4's diagnoses included high blood pressure, diabetes, irritable bowel syndrome, obesity, low thyroid levels and hyperlipidemia (high concentration of fat in blood). R4's unsigned Service Plan, dated June 6, 2023, indicated R4 received services including fall prevention, bathing reminders, toileting reminders, housekeeping, laundry, behavior monitoring, blood glucose monitoring, and medication management. R4's Medication Management Services, last reviewed July 30, 2020, indicated R4 was forgetful, lacked critical thinking, and required medication set-up. R4's Evaluation of Resident's Ability to Self-Administer Medications, dated August 1,	01760			

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01760	Continued From page 62 2021, indicated R4 had significant mental illness, had diabetes, was insulin dependent, and was not able to recall names of most medications, the side effects, and the dose. Also noted, R4's family requested medication management and administration of all medications; however, R4 could inject insulin after staff dialed up required dose. R4's record included an unsigned Appointment Details/Progress Notes from a Diabetes Center clinic visit with the certified nurse practitioner (CNP) on June 7, 2023. The CNP directed the plan was to continue diabetes medications including: - Levemir (long acting insulin) 55 units twice daily; - Novolog (short acting insulin) 10 units before each meal plus sliding scale 3 units for every 50 points for blood sugars over 150; - Jardiance (oral medication to decrease blood sugar) 10 milligrams (mg) daily; and - Victoza (helps pancreas produce more insulin) 1.2 mg daily. R4's prescriber orders dated July 14, 2023, included medication to treat high blood pressure, two oral medications to treat diabetes, two medications to decrease cholesterol and triglycerides, medication to decrease fluid retention, medication to decrease stomach acid, two laxatives, medication to treat low thyroid level, antiseizure medication, antidepressant, antipsychotics, an antihistamine to treat allergies, and three injectable medications to treat diabetes, including: - Victoza 1.2 mg SQ (subcutaneously) (under the skin) daily; - Levemir 55 units twice daily; and - Novolog per sliding scale: 7 units for <100-150	01760			

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01760	Continued From page 63 12 units for 150-200 14 units for 201-250 16 units for 251-300 18 units for 301-350. R4's Medication Record, dated August 2023, included the following directions: - Novolog FlexPen 100, Inject 10 units SQ three times daily with meals; - Novolog FlexPen 100, Correction 3 units every 50 points > 150. Staff signed their initials in each area to indicate they had given the insulin; however, lacked documentation of how much insulin had been given. On August 22, 2023, at 6:56 a.m., the surveyor observed as unlicensed personnel (ULP)-B prepared to assist R4 to check blood glucose and administer insulin. ULP-B stated R4 was independent with doing these tasks, once set up, and worked outside of the facility during the day and brought supplies to complete blood glucose check and insulin administration before lunch. ULP-B handed R4 the glucometer, and R4 performed the finger poke and announced the blood sugar was 118. Without priming the pen, ULP-B dialed the Novolog insulin pen to 10 units and handed it to R4. R4 injected the insulin into the abdomen. ULP-B dialed the Victoza pen to 1.2 mg and handed the pen to R4, which he administered into a different area of his abdomen. Without priming the pen, ULP-B dialed R4's Levemir pen to 55 units, handed the pen to R4, and he administered the insulin into a different area of his abdomen. When interviewed on August 22, 2023, at 7:02 a.m., ULP-B stated she didn't prime the Novolog and Levemir insulin pens, had never been taught	01760			

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01760	Continued From page 64 to do so, and wasn't aware that she should. ULP-B stated R4 always primed the pens when he dialed the dosage himself, but she never did. When asked to clarify the amount of Novolog insulin R4 was to receive, ULP-B stated she followed the sliding scale R4 had taped inside his glucometer case. ULP-B stated the Medication Record came from the pharmacy and was confusing, and in the past, they attached the same sliding scale in the glucometer case onto the Medication Record, but that wasn't attached anymore so they always followed the sliding scale in R4's glucometer case. R4's glucometer case contained a small piece of paper with typewritten sliding scale, that directed: 60-150 10 units 151-200 15 units 201-250 18 units 251-300 21 units 301-350 24 units 351-400 27 units >400 30 units On August 22, 2023, at 7:04 a.m., CNS/LALD-A stated she wasn't aware that some insulin pens manufacturer's guidelines directed to prime the needle prior to dialing the correct dosage. CNS/LALD-A stated the orders from R4's primary physician and the clinical nurse practioner were different and she was unable to verify what the correct orders were. The Novolog FlexPen manufacturer's prescribing information dated March 2023, directed before each injection turn the dose selector to 2 units to avoid injecting air and to ensure proper dosing. With the needle pointing upwards, press the push-button all the way in. A drop of insulin should appear. Then, turn the dose selector to	01760			

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01760	Continued From page 65 the number of units needed to inject. The Levemir FlexPen manufacturer's prescribing information dated December 2022, directed before each injection turn the dose selector to 2 units to avoid injecting air and to ensure proper dosing. With the needle pointing upwards, press the green push-button all the way in. A drop of insulin should appear. Then, turn the dose selector to the number of units needed to inject. 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 four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01820			

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01820	Continued From page 66 situation has occurred only occasionally). The findings include: During the entrance conference on August 21, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee provided medication management services to all of the licensee's residents. R2's diagnoses included seizures, wounds, generalized weakness, and incontinence. R2's Service Plan, dated May 23, 2023, indicated R2 received services including medication management. R2's Medication Record, dated August 1, 2023, through August 31, 2023, listed medications including a mild pain reliever, a medication to lower cholesterol, two medications to treat enlarged prostate, two antiseizure medications, a medication to treat low thyroid levels, three supplements, a medication to decrease inflammation, an antidepressant, a medication to prevent organ transplant rejections, an antibiotic, an antipsychotic, and medication to prevent blood clots. R2's Medication Reconciliation Form, dated February 14, 2022, listed R2's medications, including the dose, frequency, route, and the number of tablets received. R2's Evaluation of Resident's Ability to Self-Administer Medications, dated February 14, 2022, listed R2's medications and indicated R2 was totally dependent on others for medication management and medication administration.	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33450	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/23/2023
NAME OF PROVIDER OR SUPPLIER CORNERSTONE CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 23766 570TH AVENUE LITCHFIELD, MN 55355		
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01820	Continued From page 67 R2's record lacked signed current prescriber medication orders. On August 22, 2023, at 11:40 a.m., CNS/LALD-A stated the provider they used wasn't good at reviewing and signing medication orders, and they would usually look at new orders and the visit summary on My Chart (an electronic tool for patients to access their personal health information) after the residents' doctor visit; however, stated these were not signed prescriber orders, as required. The licensee's Physician Orders policy, undated, directed the licensee would maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
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 refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor medication refrigerator temperatures for one of one medication refrigerator.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33450	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/23/2023
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01880	Continued From page 68 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 21, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee provided medication management services to all of the licensee's residents, including medication storage. On August 21, 2023, at 12:29 p.m., CNS/LALD-A provided a tour of the facility, including the medication room. CNS/LALD-A stated the night shift staff monitored and logged the temperature of the medication refrigerator in the medication room and she would provide the log. When the surveyor asked what the temperature of the refrigerator should be, CNS/LALD-A stated temperatures in the "30's" was "okay." The medication refrigerator contained five unopened Novolog (short acting insulin) FlexPens, two unopened Victoza (used to treat diabetes) pens, eight unopened Levemir (long acting insulin) Flexpens, two unopened Trulicity (helps to control blood sugar levels) Pens, and two unopened Basaglar (long acting insulin) KwikPens. On August 21, 2023, at 12:50 p.m., CNS/LALD-A provided the temperature logs for the medication refrigerator, dated November 2, 2022, through August 20, 2023, and the documentation	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33450	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/23/2023
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01880	Continued From page 69 indicated the following: - April 8, 2023 - 30 degrees Fahrenheit (F); - April 9, 2023 - 35 degrees F; - June 24, 2023 - 35 degrees F; - June 30, 2023 - 31 degrees F; - July 1, 2023 - 29 degrees F; - July 2, 2023 - 35 degrees F; - July 6, 2023 - 33 degrees F; - July 7, 2023 - 35 degrees F; - July 14, 2023 - 35 degrees F; - July 22, 2023 - 34 degrees F; - August 11, 2023 - 30 degrees F; - August 12, 2023 - 30 degrees F; - August 13, 2023 - 33 degrees F; - August 14, 2023 - 35 degrees F; - August 15, 2023 - 35 degrees F; - August 16, 2023 - 29 degrees F; and - August 17, 2023 - 30 degrees F. On August 21, 2023, at 12:55 p.m., CNS/LALD-A stated she did not know the manufacturer's recommended temperatures for the medications stored in the medication refrigerator and stated she had not directed staff to call when temperatures were out of the recommended temperature range. The manufacturer's instructions for Levemir, dated December 2022, indicated store unused pens in the refrigerator between 36-46 degrees Fahrenheit (F. Do not freeze, do not use if Levemir has been frozen. The manufacturer's instructions for Trulicity, dated January 2023, indicated store Pen in the refrigerator between 36-36 degrees F. Do not freeze. If Pen has been frozen, throw the Pen away and use a new Pen. The manufacturer's instructions for Novolog	01880			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CORNERSTONE CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 23766 570TH AVENUE LITCHFIELD, MN 55355		
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01880	Continued From page 70 FlexPens, dated March 2023, indicated storage in the refrigerator at 36-46 degrees F. The manufacturer's instructions for Victoza, dated July 2023, indicated prior to first use, Victoza should be stored in a refrigerator between 36-46 degrees F. Do not freeze and do not use if it has been frozen. The manufacturer's instructions for Basaglar, dated August 2023, indicated unused pens should be refrigerated between 36-46 degrees F, and not used if allowed to freeze. The licensee's undated Storage/Control of Medications policy indicated medications requiring refrigeration would be clearly labeled and temperature maintained at 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01920 SS=F	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.	01920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33450	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/23/2023
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01920	Continued From page 71 (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: Based on interview and record review, the licensee failed to develop and implement procedures for loss and spillage of all controlled substances defined in Minnesota Rules part 6800.4220. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 21, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents, including storage of controlled substances. On August 22, 2023, at 12:10 p.m., CNS/LALD-A stated the licensee lacked a procedure for loss or spillage of controlled substances, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01920			

Minnesota Department of Health

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01920	Continued From page 72	01920			
02310 SS=I	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 provide care and services according to the acceptable health care medical or nursing standards for medication set up by unlicensed personnel (ULP) for other ULP's to adminiiter at a later time. 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 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: Minnesota Statute 144G.08, Subdivision 41 dated 2022, stated "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. During the entrance conference on August 21,	02310			

Minnesota Department of Health

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02310	Continued From page 73 2023, at 10:18 a.m., clinical nurse supervisor (CNS)/licensed assisted living director (LALD)-A stated the licensee provided medication management services to all of the licensee's residents. CNS/LALD-A stated (ULP)-B set up all four of the residents' medications on Mondays, from medication bottles into pill boxes, for the other ULP staff to administer during the week. On August 21, 2023, at 12:47 p.m., the surveyor observed while ULP-B set up R5's medications into pill boxes from medication bottles, for later administration by unlicensed staff. ULP-B stated she was trained by CNS/LALD-A recently to set up medications, because the ULP that was doing this was terminated a week ago. ULP-B stated she did not document the medication setup to include date of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, or name of the person completing medication setup, as required. R5's diagnoses included atrial fibrillation (irregular and often rapid heart rhythm), high blood pressure, coronary artery disease, history of heart attack, diabetes, generalized anxiety, hallucinations, delusions, alcoholism, and suicidal ideation. R5's unsigned Service Plan, dated June 6, 2023, indicated R5 was dependent on staff for medication management services including all medications per provider's orders and staff attending all essential visits. R5's Medication Record, dated August 2023, included two injectable medications to improve blood glucose levels, one antipsychotic, two medications to treat high blood pressure, a blood	02310			

Minnesota Department of Health

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02310	Continued From page 74 thinner, and medication to lower cholesterol. R5's record lacked documentation at the time of medication setup to include the date of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of the person completing medication setup. During an interview on August 21, 2023, at 12:50 p.m., CNS/LALD-A stated she was not aware that unlicensed personnel could not set up medications for later administration, and stated this was the responsibility of the lead ULP for all four residents. The licensee's undated Medication Documentation policy, indicated the licensee would document medication set up according to the following: - date of medication set up; - name of medication; - quantity of dose; - times to be administered; - route of administration; and - name/title of person completing medication set up. Also included, documentation of medication set up will be completed promptly. The licensee's undated Storage/Control of Medications policy indicated, as specified in the resident's medication management program, a licensed nurse will regularly set up medications in a clearly labeled container based on the resident's medication regimen. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2)	02310			

Minnesota Department of Health

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02310	Continued From page 75 days	02310			

Type: Full
Date: 08/21/23
Time: 11:14:33
Report: 1041231105

Food and Beverage Establishment Inspection Report

Page 1

Location:

Cornerstone Care Llc
23766 570th Avenue
Litchfield, MN55355
Meeker County, 47

Establishment Info:

ID #: 0038020
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123100655
ID #:

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

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

EMPLOY A CERTIFIED FOOD PROTECTION MANAGER. MICHELLE BOGATZKI AND SANDRA LAHTINEN HAVE TAKEN SERVSAFE CLASSES. ONE OF THEM WILL NEED TO APPLY FOR THE STATE CERTIFICATE.

Comply By: 09/18/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

SLOW COOKER, INSTANT POT AND AIR FRYER ARE NOT APPROVED. REMOVE OR REPLACE WITH APPROVED EQUIPMENT.

Comply By: 09/18/23

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

REHEATING AND SERVING LEFTOVERS IS NOT ALLOWED. DISCONTINUE SERVING LEFTOVERS.

Comply By: 08/22/23

Type: Full
Date: 08/21/23
Time: 11:14:33
Report: 1041231105
Cornerstone Care Llc

Food and Beverage Establishment Inspection Report

Page 2

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

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

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

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

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 1041231105 of 08/21/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____
Establishment Representative

Signed: Linda Heinen
Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us