DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 13, 2023

Licensee
The Meadows Of Mabel
610 Newburg Street East
Mabel, MN 55954

RE: Project Number(s) SL30471015

Dear Licensee:

On November 8, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 31, 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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

PMB

Electronically Delivered

September 28, 2023

Licensee
The Meadows Of Mabel
610 Newburg Street East
Mabel, MN 55954

RE: Project Number(s) SL30471015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 31, 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 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30471	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

(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: SL30471015 On August 28, 2023, through August 31, 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 13 active residents; 13 receiving services under the Assisted Living Facility license. 1750: The immediacy of correction order was lifted on August 31, 2023; however, non-compliance remains at a scope and level of I (level 3, widespread).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 29, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 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 by: Based on observation, interview, and record review the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of one unlicensed personnel (ULP-D) observed during medication administration. 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: R4's Addendum A service plan signed June 13, 2023, indicated the resident received services including medication administration. The description of the service indicated: Administer medications from bubble pack at scheduled medication passing times. Must observe tenant take the medications. On August 23, 2023, at 7:25 a.m. ULP-D entered	0 510		

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0 510	Continued From page 3 R4's apartment and R4 was observed seated in her recliner. ULP-D then obtained R4's medications from a locked drawer in R4's kitchen and proceeded to set-up the medications. ULP-D punched each prescribed medication out of the blister pack card it was packaged in, onto a ceramic spoon rest in R4's kitchen. ULP-D stated R4 would then bring the medications out to the dining room once R4 was ready to eat breakfast. R4's medications included potassium chloride micro tab 20 milliequivalents daily. ULP-D stated R4 would usually ask staff to break this medication in half due to it's size making it easier for R4 to swallow. ULP-D further stated if R4 wanted it broken in half, R4 would do that once R4 came into the dining room. Once ULP-D had set up all 13 of R4's prescribed AM medications, ULP-D instructed R4 to bring them to the dining room when R4 came out to breakfast. ULP-D then exited R4's apartment, assisted another resident, then went to the kitchenette to get ready for the breakfast meal. At approximately 8:10 a.m., R4 was observed walking independently into the dining room; R4 did not have her medications with her. ULP-D was in the kitchenette at this time plating up food for the residents who were already in the dining room. ULP-D directed R4 to return to her room and bring her medications back with her, which R4 did. Upon return to the dining room, R4 was observed with her medications. The medications were no longer on the ceramic spoon rest that ULP-D had administered them into - they were now in a disposable plastic cup. R4 set the medications on the table and waited for her food to arrive prior to taking. ULP-D delivered R4's meal to the table at approximately 8:17 a.m.; R4 then started taking her pills out of her cup to take with her oatmeal. At that time, R5 had arrived and sat across the table from R4. R4 stated to	0 510		

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0 510	Continued From page 4 R5 that they usually broke one of her medications in half but that hadn't been done, and she couldn't do it herself. R5 offered to break the medication for R4; R4 then handed her medication cup to R5. R5 removed the potassium chloride medication from the cup and broke it in half with her bare hands but dropped one half of the medication on the floor. R5 was unable to locate the medication and told this to R4 while handing back the medications. R4 stated she wasn't worried about it; R5 responded, "Well I am". Shortly after, ULP-D came over to the table and asked R5 what she wanted for breakfast. Neither R4 or R5 informed ULP-D of the dropped medication. At 8:25 a.m., ULP-D brought R5's meal to the table; again, neither resident informed ULP-D of the dropped medication. At 8:43 a.m., ULP-D approached R4's table and asked if she had taken all her medications; R4 response yes. R5 then stated she (R4) was missing one. R4 then stated that one of them had dropped on the floor. ULP-D stated, "Why didn't you tell me sooner?" ULP-D then located the medication on the floor near R5's chair and picked it up with her bare hands. R4 asked for the medication and ULP-D stated she could get a new pill from the nurse. R4 stated that wasn't necessary; ULP-D then handed R4 the medication and stated, "That always disgusts me when you do that". R4 then ingested the half pill of potassium chloride that was picked up from the floor. On August 29, 2023, at 2:40 p.m. RN-B stated staff were able to set up R4's medications prior to breakfast as the resident liked to take her medications with her oatmeal. RN further stated the expectation was that staff were to watch R4 take her medications and not allow another resident to touch R4's medications. RN-B further stated would not expect staff to handle	0 510		

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0 510	Continued From page 5 medication with their bare hands and then give to the resident from the floor. The licensee's Medication Administration policy revised June 1, 2023, indicated: If a medication is inadvertently dropped on the floor in the resident's apartment, the resident will be allowed to take the medication after picking it up with gloves on and wiping it with a paper towel. It will be at the resident's discretion if they want to have the medication wiped off if they choose to take it or request that the medication be disposed of. The licensee's Using Gloves policy updated July 29, 2021, indicated: a) When gloves are indicated, disposable single-use gloves should be worn. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of	0 660		

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0 660	Continued From page 6 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 complete a facility tuberculosis (TB) risk assessment. This practice resulted in a level two violation (a violation that did no 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 29, 2023, at 11:29 a.m. registered nurse (RN)-B provided a facility TB risk assessment dated February 9, 2023, for the attached nursing home facility. On August 29, 2023, at 2:41 p.m. RN-B stated she was not aware that the licensee required its own TB risk assessment and thought the nursing home TB risk assessment covered the entire campus. The licensee's TB infection control policy dated June 1, 2023, indicated the licensee would have an infection control program in place to ensure that all residents, employees, volunteers, and guest are free from infectious tuberculosis. All health care settings were required by law to follow specific guidelines and measures to prevent and control TB in facilities and the facility TB risk	0 660		

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0 660	Continued From page 7 assessment would be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	0 730		

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0 730	Continued From page 8 resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on May 17, 2022, and discharged to another facility on October 19, 2022. R3's record lacked a discharge summary.	0 730		

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0 730	Continued From page 9 On August 29, 2023, at 8:15 a.m., registered nurse (RN)-B stated R3's record lacked a discharge summary. RN-B further stated a discharge summary should have been completed when R3 discharged to another facility. The licensee's comprehensive assessment schedule policy dated July 1, 2023, indicated the nurses shall conduct assessments, monitoring, and reassessments consistent with assisted living licensure requirements and the individualized needs of each resident. It further indicated the discharge summary would be completed no later than the date of discharge. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous	0 800		

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0 800	Continued From page 10 state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On facility tour with the Director of Maintenance (DM)-E, between approximately 9:00 AM and 11:00 AM on August 30, 2023, it was observed that the fire door to the first floor laundry room was being held open by a door stop. Fire doors must not be held open unless done so by devices that release upon fire alarm activation so that the doors close and latch to prevent fire from spreading to or from the area. This deficient condition was visually verified by DM-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping	0 810		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

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0 810	Continued From page 11 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 interview and record review, the licensee failed to develop and maintain a fire safety and evacuation plan that shows the employee actions to be taken in the event of fire or similar emergency and failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors.	0 810		

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0 810	Continued From page 12 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: A record review and interview were conducted with Director of Maintenance (DM)-E on August 30, 2022, at approximately 11:00 a.m. on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. During record review of the provided documents, no documents were available that showed employee actions to be taken in the event of a fire or similar emergency. Additionally, no records were provided that showed that the employees received training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. During interview, DM-E stated that employees only received training upon hiring on fire safety and evacuation. The employees covered additional topics during fire drills, but training was not being done twice annually as required. Additionally, he stated that the fire safety and evacuation plan did not provide documents that show the employee actions to be taken in the event of a fire or similar emergency. These deficient conditions were verified by DM-E	0 810		

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0 810	Continued From page 13 during interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	01060		

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01060	Continued From page 14 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation 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 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: R2 began receiving assisted living services from the licensee on May 2, 2023. R2's Addendum A service plan signed May 2, 2023, indicated R2 received services which included bathing, dressing, grooming, toileting, housekeeping, laundry, medication administration, blood glucose monitoring, and assistance with compression stockings.	01060		

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01060	Continued From page 15 R2's progress notes revealed the resident had been hospitalized on May 30, 2023, due to cellulitis of the left lower extremity and was being treated with IV (intravenous) antibiotics. The progress notes further revealed R2 returned to the assisted living facility on June 1, 2023. On August 29, 2023, at 2:40 p.m. registered nurse (RN)-B stated she gave R2 the emergency relocation notice though did not make a copy of it for the resident's chart. RN-B checked with R2 to see if the resident still had the emergency relocation notice but the resident couldn't locate it. The licensee's Notice of Emergency Relocation policy updated December 20, 2022, indicated: Resident, resident's designated representative, and the resident's legal representative(s) will be given a Notice of Emergency Relocation for any relocation to acute care, an emergency department (ED), or any other emergent relocation from the community. The notice will be given prior to or within 48 hours of relocation from the community. The policy further indicated a copy must be placed in the resident medical record. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	01290		

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01290	Continued From page 16 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living (ALF) license for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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-F was hired on May 19, 2020, to provide direct care services to the facility's residents. ULP-F's employee record contained a Background Study Clearance dated August 24, 2017, from the attached skilled nursing facility. However, the document was not affiliated with the	01290		

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01290	Continued From page 17 facility's license. On August 30, 2023, at 11:50 a.m. executive director (ED)-A stated ULP-F had worked at the attached skilled nursing facility (SNF) and transferred to the ALF which was why her background study was affiliated with the SNF. ED-A stated the SNF and ALF were the same entity and therefore did not believe ULP-F had to have a background study affiliated with the ALF. The licensee's employee standards and code of conduct policy, undated, indicated criminal background checks would be conducted on all employees and volunteers in accordance with state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the	01440		

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01440	Continued From page 18 interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two 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 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: ULP-D was employed by a staffing agency and began providing services for this licensee on February 5, 2023. On August 29, 2023, at 7:25 a.m. ULP-D was observed setting up medications for administration for R4. At 7:35 a.m., ULP-D was	01440		

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01440	Continued From page 19 observed applying compression stockings to R6's legs. ULP-D's employee record lacked documentation of a registered nurse (RN) supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee. On August 31, 2023, at 9:51 a.m. RN-B confirmed she had not completed a 30-day supervision for ULP-D as the ULP was agency staff, and RN-B did not know of the requirement. The licensee's Delegation and Supervision of Unlicensed Personnel policy revised June 1, 2023, indicated: Staff providing delegated nursing or therapy home care tasks will be competent and supervised by an RN. Supervision will include observation of the staff administering the medication or treatment and the interaction with residents. 5. ULP must be supervised by an RN within 30 days after the individual begins working for the assisted living and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;	01470		

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01470	Continued From page 20 (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased	01470		

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01470	Continued From page 21 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-D, registered nurse (RN)-G) received orientation to assisted living facility licensing requirements and regulations before providing 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: ULP-D ULP-D was employed by a staffing agency and began providing services for this assisted living provider on February 5, 2023. On August 29, 2023, at 7:25 a.m. ULP-D was observed setting up medications for administration for R4. At 7:35 a.m., ULP-D was observed applying compression stockings to R6's	01470		

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01470	Continued From page 22 legs. ULP-D's employee record did not include the following required orientation content: - an overview of the 144G statutes - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure, and; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. RN-G RN-G was hired on July 12, 2023, to provide casual on-call services to the licensee's residents. RN-G's employee record did not include the following required orientation content: - an overview of the 144G statutes - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470		

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01470	Continued From page 23 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure, and; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On August 30, 2023, at 3:41 p.m. executive director (ED)-A and registered nurse (RN)-B reviewed the above employees' transcripts and stated not all components of the required orientation training for assisted living facilities had been completed. The licensee's Orientation for Assisted Living Staff (144G.63) policy dated August 1, 2021, indicated: 2. Content of required orientation. The orientation must contain the following topics: (1) An overview of sections 144G.01 to 144G9999 (2) Introduction and review of all the provider's policies and procedures related to the provision of assisted living services by the individual staff person; (6) The principles of person-centered planning and service deliver and how they apply to direct support services provided by the staff person; (8) Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, or other relevant advocacy services; and (9) Review of the types of assisted living services the employee will be providing and the	01470		

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01470	Continued From page 24 facilities category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30471	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

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01620	Continued From page 25 (RN) completed a resident assessment within 14 days of admission for two of two residents (R2, R1) and failed to complete a change of condition assessment for one of one resident (R2) upon return from hospitalization. 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: R2 R2 was admitted on May 2, 2023, with diagnoses including diabetes, hypertension (high blood pressure), chronic kidney disease, coronary artery disease with history of myocardial infarction (heart attack), acquired absence (amputation) of right leg below the knee and of other left toes, and hyperlipidemia (high cholesterol). R2's Addendum A service plan signed May 2, 2023, indicated R2 received services which included bathing, dressing, grooming, toileting, housekeeping, laundry, medication administration, blood glucose monitoring, and assistance with compression stockings. R2's record included a pre-admission assessment dated April 25, 2023, and a 14-day supervisory visit dated May 17, 2023 (15 days after start of services). The 14-day Supervisory Visit was a one-page document that indicated the	01620		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

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01620	Continued From page 26 service plan was reviewed, staff were performing duties according to the service plan and were directly observed, and resident was satisfied, and needs were met with the service plan. The 14-day Supervisory Visit did not meet the criteria of a Uniform Assessment Tool. R2's progress notes revealed the resident had been hospitalized on May 30, 2023, due to cellulitis of the left lower extremity and was treated with IV (intravenous) antibiotics. The progress notes further revealed R2 returned to the assisted living facility on June 1, 2023. R2's medical record did not include evidence a change of condition assessment had been completed upon return from the hospital. On August 29, 2023, at 2;40 p.m. RN-B stated she did not conduct a full uniform assessment at 14 days for R2, although RN-B did complete a supervisory assessment that did not include all criteria. RN-B further stated she did not complete a change of condition assessment for R2 upon return from hospitalization. RN stated R2's level of care hadn't changed, but R2 was being treated for a cellulitis infection and returned on oral antibiotics. R1 R1 was admitted on August 4, 2023, with diagnoses including type 2 diabetes, hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm), venous insufficiency (failure to the veins to adequately circulate blood from lower extremities), asthma, anxiety, dry eyes, hyperlipidemia (high cholesterol), osteoarthritis, urinary stress incontinence and depression. R1's service plan dated August 21, 2023,	01620		

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THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

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01620	Continued From page 27 indicated R1 received services to include assistance with meals, housekeeping, laundry, showers, compression stockings and medication management. R1's record included an initial assessment completed on August 1, 2023. R1's record lacked evidence of a 14-day comprehensive nursing assessment. On August 29, 2023, at 10:18 a.m. RN-B confirmed R1's record did not contain a 14-day nursing assessment. RN-B stated she would usually check in with the resident after a couple of weeks to see how things were going but had not completed an assessment. The licensee's comprehensive assessment schedule policy dated July 1, 2023, indicated the nurses would conduct assessments, monitoring, and reassessments consistent with assisted living requirements and the individualized needs of each resident. It further indicated a resident monitoring and reassessment would be completed within 14 days after initiation of services, and at least every 90 days thereafter or with change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living	01640		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 28 facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current written service plan was finalized no later than 14 calendar days after the date that services were first provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01640		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

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01640	Continued From page 29 R1 was admitted on August 4, 2023. R1's diagnoses included type 2 diabetes, hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm), venous insufficiency (failure to the veins to adequately circulate blood from lower extremities), asthma, anxiety, dry eyes, hyperlipidemia (high cholesterol), osteoarthritis, urinary stress incontinence and depression. R1's service plan dated August 21, 2023, indicated R1 received services to include assistance with meals, housekeeping, laundry, showers, compression stockings and medication management. R1 began receiving assisted living services on August 4, 2023. R1's service plan was finalized and signed by R1 on August 21, 2023, 18 days after R1 began receiving services. On August 29, 2023, at 11:25 a.m. registered nurse (RN)-B stated R1's service plan was not finalized and signed within 14 calendar days of the date R1 started services. RN-B stated she had waited to finalize R1's service plan because she thought R1 had qualified for the Elderly Waiver (EW) program and wanted the county rates to add to the service plan. RN-B stated once she was notified that R1 would not be enrolled in the EW program she met with R1 to sign the service plan. The licensee's service plan policy dated June 1, 2023, indicated the assisted living provider shall finalize a written service plan within 14 days after the initiation of assisted living services to the resident.	01640		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

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01640	Continued From page 30 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered	01730		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

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01730	Continued From page 31 as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R2, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 28, 2023, at 12:20 p.m. registered nurse (RN)-B confirmed the licensee provided medication management services to the residents at the facility. R2 R2's diagnoses included diabetes, hypertension (high blood pressure), chronic kidney disease,	01730		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01730	Continued From page 32 coronary artery disease with history of myocardial infarction (heart attack), hyperlipidemia (high cholesterol), asthma, depression, and anxiety. R2's Addendum A service plan signed May 2, 2023, indicated R2 received medication administration. R2's physician orders signed June 15, 2023, included two medications for cholesterol, three for blood pressure, one blood thinner, two for depression and anxiety, one for diabetes, two for asthma, and one diuretic for fluid retention. R1 R1's diagnoses included type 2 diabetes, hypertension, atrial fibrillation (abnormal heart rhythm), venous insufficiency (failure to the veins to adequately circulate blood from lower extremities), asthma, anxiety dry eyes, hyperlipidemia, osteoarthritis, urinary stress incontinence and depression. R1's Addendum A service plan, dated August 21, 2023, indicated R1 received services to include medication management. R1's physician orders signed July 26, 2023, included one medication cholesterol, one for blood pressure, one blood thinner, one for depression and anxiety, one for diabetes, two for asthma, one for seasonal allergies, one for overactive bladder, one for constipation, and one diuretic for fluid retention. R2 and R1's individual medication management plans lacked: -procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services	01730		

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THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

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01730	Continued From page 33 On August 31, 2023, at 9:51 a.m. RN-B reviewed the Individualized Medication Management Plan template used for all residents and stated it did not include the above required content. The licensee's Individualized Medication Management Plan policy revised June 1, 2023, did not include the above content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-D) completed training and competency evaluations for medication administration by a registered nurse (RN). This had the potential to affect all residents receiving	01750		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

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01750	Continued From page 34 medication administration. This resulted in an immediate correction order identified on August 30, 2023, at 1:38 p.m. 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: ULP-D was employed by a staffing agency and began providing services for this assisted living provider on February 5, 2023. On August 23, 2023, at 7:25 a.m. ULP-D entered R4's apartment and R4 was observed seated in her recliner. ULP-D then obtained R4's medications from a locked drawer in the R4's kitchen and proceeded to set-up the medications. ULP-D punched each prescribed medication out of the blister pack card it was packaged in, onto a ceramic spoon rest in R4's kitchen. ULP-D stated R4 would then bring the medications out to the dining room once she was ready to eat breakfast. R4's medications included potassium chloride micro tab 20 milliequivalents daily. ULP-D stated R4 would usually ask staff to break this medication in half due to it's size making it easier for her to swallow. ULP-D further stated if R4 wanted it broken in half, she would do that once the resident came into the dining room. Once ULP-D had set up all 13 of R4's prescribed AM medications, ULP-D instructed R4 to bring them to the dining room when she came out to	01750		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

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01750	Continued From page 35 breakfast. ULP-D then exited R4's apartment, assisted another resident, then went to the kitchenette to get ready for the breakfast meal. At approximately 8:10 a.m., R4 was observed walking independently into the dining room; R4 did not have her medications with her. ULP-D was in the kitchenette at this time plating up food for the residents who were already in the dining room. ULP-D directed R4 to return to her room and bring her medications back with her, which R4 did. Upon return to the dining room, R4 was observed with her medications. The medications were no longer on the ceramic spoon rest that ULP-D had administered them into - they were now in a disposable plastic cup. R4 set the medications on the table and waited for her food to arrive prior to taking. ULP-D delivered R4's meal to the table at approximately 8:17 a.m.; R4 then started taking her pills out of her cup to take with her oatmeal. At that time, R5 had arrived and sat across the table from R4. R4 stated to R5 that they usually broke one of her medications in half but that hadn't been done, and she couldn't do it herself. R5 offered to break the medication for R4; R4 then handed her medication cup to R5. R5 removed the potassium chloride medication from the cup and broke it in half with her bare hands but dropped one half of the medication on the floor. R5 was unable to locate the medication and told this to R4 while handing back the medications. R4 stated she wasn't worried about it; R5 responded, "Well I am". Shortly after, ULP-D came over to the table and asked R5 what she wanted for breakfast. Neither R4 or R5 informed ULP-D of the dropped medication. At 8:25 a.m., ULP-D brought R5's meal to the table; again, neither resident informed ULP-D of the dropped medication. At 8:43 a.m., ULP-D approached R4's table and asked if she had taken all her medications; R4 response yes. R5	01750		

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	30471	A. BUILDING: _____ B. WING _____	08/31/2023

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01750	Continued From page 36 then stated she (R4) was missing one. R4 then stated that one of them had dropped on the floor. ULP-D stated, "Why didn't you tell me sooner?" ULP-D then located the medication on the floor near R5's chair and picked it up with her bare hands. R4 asked for the medication and ULP-D stated she could get a new pill from the nurse. R4 stated that wasn't necessary; ULP-D then handed R4 the medication and stated, "That always disgusts me when you do that". R4 then ingested the half pill of potassium chloride that was picked up from the floor. On August 29, 2023, at 2:40 p.m. RN-B stated staff were able to set up R4's medications prior to breakfast as the resident liked to take her medications with her oatmeal. RN further stated the expectation was that staff were to watch R4 take her medications and not allow another resident to touch R4's medications. RN-B further stated would not expect staff to handle medication with their bare hands and then give to the resident from the floor. ULP-D's employee file lacked evidence training and competencies for medication administration had been completed by a RN. On August 30, 2023, at 11:42 a.m. RN-B stated to her knowledge ULP-D was not trained and competency tested on medication administration by the facility. RN-B stated the staffing agency that employed ULP-D sent them verification ULP-D had a TMA (trained medication aide) certificate but was unaware this did not include training on insulin administration. RN-B stated ULP-D had been administering insulin since picking up shifts at the facility and further stated they currently have two residents who received insulin administration from the staff. RN-B stated	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30471	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

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01750	Continued From page 37 being unaware the facility needed to provide their own medication administration training/testing for agency unlicensed staff. On August 30, 2023, at 11:47 a.m. ULP-D stated having a TMA certificate and also had been trained by other facilities on medication and insulin administration, but had not received medication or insulin administration training from this facility. On August 30, 2023, at 11:50 a.m. executive director (ED)-A stated ULP-D did not receive medication administration training at the facility as had a TMA certificate for passing medications. ED-A was unaware TMA training did not include insulin administration. The licensee's Medication Administration policy revised June 1, 2023, indicated a RN must instruct the ULP on the following medication administration tasks before delegating the task to them: - The complete procedure of checking a residents medications administration record (MAR). - The preparation of medication for administration. - The administration of the medication to the tenant. - The reminder to self-administer medications. - The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, the method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or person who assisted or administered and observed the same. The ULP must demonstrate their ability to competently follow the delegated medication	01750		

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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
01750	Continued From page 38 administration to a RN. Written records, signed by a RN, shall be maintained regarding ULP training and competency testing of delegated medication administration. If a medication is inadvertently dropped on the floor in the resident's apartment, the resident will e allowed to take the medication after picking it up with gloves on and wiping it with a paper towel. It will be at the resident's discretion if they want to have the medication wiped off, it they choose to take it or request that the medication be disposed of. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed by evaluation supervisor review on August 31, 2023; however, noncompliance remains at a scope and severity of l. The licensee failed to ensure the RN specified, in writing, specific instructions for one of one resident (R1) whose medication administration was delegated to unlicensed personnel. R1's diagnoses included type 2 diabetes, hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm), venous insufficiency (failure to the veins to adequately circulate blood from lower extremities), asthma, anxiety, dry eyes, hyperlipidemia (high cholesterol), osteoarthritis, urinary stress incontinence and depression. R1's Addendum A service plan dated August 21, 2023, identified services included medication administration.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30471	A. BUILDING: _____ B. WING _____	08/31/2023

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01750	Continued From page 39 R1's physician orders dated July 26, 2023, included: -Refresh Optive Eye drops (used for dry eyes) use 1-2 drops as needed. The licensee failed to have resident-specific instructions regarding when to administer one or two eye drops. On August 29, 2023, at 2:42 p.m. RN-B stated there were no specific instructions for R1's eye drops. RN-B further stated staff need to know when to give the ordered dosages. The licensee's medication and treatment orders policy dated December 2022, indicated the content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. No further information was provided. Time Period for Correction: Seven (7) days	01750		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of	01910		

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01910	Continued From page 40 medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on May 17, 2022, and discharged to another facility on October 19, 2022. R3's service plan dated May 17, 2022, indicated R3 received assistance with medication management. R3's record lacked a medication disposition record at the time of discharge to include the medication's name, strength, prescription number	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30471	A. BUILDING: _____ B. WING _____	08/31/2023

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THE MEADOWS OF MABEL	610 NEWBURG STREET EAST MABEL, MN 55954

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01910	Continued From page 41 as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On August 29, 2023, at 8:15 a.m. registered nurse (RN)-B reviewed R3's record and stated disposition of mediations had not been completed at the time of R3's discharge. The licensee's medication operational procedures policy dated June 1, 2023, indicated the licensee would document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	01940		

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01940	Continued From page 42 provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R2, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01940		

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01940	Continued From page 43 During the entrance conference on August 28, 2023, at 12:20 p.m., registered nurse (RN)-B stated the licensee provided treatment management services to residents, including assistance with compression stockings and blood sugar monitoring. R2 R2's Addendum A service plan signed May 2, 2023, indicated R2 received services which included assistance with TED (thrombo-embolic-deterrent) hose (compression stockings used to decrease fluid and increase circulation) two times daily. The service plan directed staff to assist with applying compression socks bilaterally to lower extremities every a.m., and assist with removing compression socks and wash every p.m. The service plan also included blood sugar monitoring daily and directed staff to check R2's blood glucose before breakfast and record value on the service sheet. R2's Treatment/Therapy Management Plan dated August 2, 2023, indicated the resident received treatments including blood glucose monitoring and compression garments/TEDS. The plan also indicated a RN was available 24/7 either in person or by phone for staff to report problems or concerns with treatments or therapy management services. R2's record lacked a treatment management plan that was individualized to include procedures for notifying a registered nurse (RN) when a problem arose with specific criteria on when to notify the RN. On August 29, 2023, at 2:40 p.m. RN-B reviewed	01940		

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01940	Continued From page 44 R2's treatment management plan and stated it did not include procedures for notifying a nurse related to the resident's compression stockings. RN-B further stated R2's plan did not include parameters for blood sugars on when to notify a nurse. R1 R1 was admitted on August 4, 2023, and had diagnoses to include type 2 diabetes, hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm), venous insufficiency (failure to the veins to adequately circulate blood from lower extremities), asthma, anxiety, dry eyes, hyperlipidemia (high cholesterol), osteoarthritis, urinary stress incontinence and depression. R1's Addendum A service plan dated August 21, 2023, included assistance with compression stockings two times daily with a.m. and HS (hour of sleep/bedtime) cares. The service plan directed staff to put on in the morning, take off at night and hand wash. R1's treatment/therapy management plan dated August 1, 2023, indicated R1 had compression garments/TEDS. R1's record lacked a treatment management plan to include the following required content: -procedures for notifying a registered nurse when problems arose with treatments and therapy services On August 29, 2023, at 2:40 p.m. RN-B reviewed R1's treatment management plan and stated it did not include procedures for notifying a nurse related to R1's compression stockings.	01940		

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01940	Continued From page 45 The licensee's Individualized Treatment Plan policy revised June 1, 2023, indicated: For each resident receiving management of ordered or prescribed treatments or therapy services, assisted living service provider must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. There must be an individualized treatment plan that includes the following: 4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of two residents (R1, R2) receiving treatments.	01970		

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01970	Continued From page 46 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: R2's diagnoses included diabetes, chronic kidney disease, coronary artery disease, and hypertension (high blood pressure). R2's Addendum A service plan signed May 2, 2023, indicated R2 received services which included assistance with TED (thrombo-embolic-deterrent) hose (compression stockings) two times daily. The service plan directed staff to assist with applying compression socks bilaterally to lower extremities every a.m., and assist with removing compression socks and wash every p.m. R2's physician orders signed June 15, 2023, did not include an order for compression stockings. R1 R1's diagnoses to include venous insufficiency (failure to the veins to adequately circulate blood from lower extremities), type 2 diabetes, hypertension (high blood pressure), atrial fibrillation (abnormal heart rhythm) and depression. R1's service plan dated August 21, 2023, included assistance with compression stockings	01970		

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01970	Continued From page 47 two time daily with a.m. and HS (hour of sleep/bedtime) cares. The service plan directed staff to put on in the morning, take off at night and hand wash. R1's record lacked physician orders for compression stockings. On August 29, 2023, at 2:40 p.m. registered nurse (RN)-B reviewed R2 and R1's medical records and could not find evidence of a physician order for compression stockings. The licensee's Medication & Treatment Orders policy revised December 2022, indicated a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions that are to be implemented must be received from a authorized prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/29/23*
Time: 08:56:40
Report: 8044231311

Food and Beverage Establishment Inspection Report

Location:
The Meadows Of Mabel
610 Newburg Street East
Mabel, MN55954
Fillmore County, 23

Establishment Info:
ID #: 0039258
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074935995
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.

2-300 Personal Cleanliness

2-301.14A ***** Priority 1 *****

MN Rule 4626.0075A Food employees must wash their hands before: food preparation activities, including working with exposed food; touching clean equipment and utensils; touching unwrapped single-service and single-use articles.

Observed staff handle clean dishes with hands contaminated from dirty dishes.

Hands washed upon request.

Comply By: 08/29/23

5-200B Plumbing: cross connections

5-203.14A ***** Priority 1 *****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

No air gap for water softener discharge line.

Comply By: 09/12/23

4-300 Equipment Numbers and Capacities

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

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

No thermometer or stickers for dishwasher.
Comply By: 09/29/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

Broken digital rinse cycle read-out thermometer for dishwasher.
Comply By: 09/29/23

Surface and Equipment Sanitizers

Hot Water: = at 161.8 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 40.8 Degrees Fahrenheit - Location: Milk fridge
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38.0 Degrees Fahrenheit - Location: Fridge
Violation Issued: No

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

HRD inspection conducted with Nicole Hunger and nursing evaluator Wendy Buckholz.

Inspection report reviewed on site with Dietary Manager, Sam.

Type: Full
Date: *08/29/23*
Time: 08:56:40
Report: 8044231311
The Meadows Of Mabel

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8044231311 of 08/29/23.

Certified Food Protection Manager: Samantha A. Neuzil

Certification Number: FM37077 Expires: 01/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Inspector signed for Sam

Signed: _____
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-206-4715
michael.demars@state.mn.us