DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 1, 2022

Administrator
Moose Lake Village Assisted Living
4560 County Highway 61
Moose Lake, MN 55767

RE: Project Number SL20329015

Dear Administrator:

On July 20, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 11, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze

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

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Electronically Delivered

June 7, 2022

Administrator
Moose Lake Village Assisted Living
4560 County Highway 61
Moose Lake, MN 55767

RE: Project Number SL20329015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 11, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

Sincerely,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#20329015 On May 9, 2022, through May 11, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 11 residents, whom were receiving services under the provider's Assisted Living license. An immediate correction order was identified on May 9, 2022, issued for SL#20329015, tag identification 2310. On May 9, 2022, the immediacy of correction order 2310 was rmoved, however non-compliance remained at an isolated scope and level three (G).	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.	
0 510 SS=D	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (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 by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of one unlicensed personnel (ULP-D) during personal cares for 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's diagnoses included diabetes with other circulatory complications, hypertensive heart disease (a condition caused by high blood pressure over a length a time), and congestive heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs), retention of urine, and benign prostatic	0 510		

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0 510	Continued From page 2 hyperplasia (prostate gland enlargement that can cause urination difficulty). On May 10, 2022, at 6:43 a.m., the surveyor observed ULP-D assist R3 with personal cares. ULP-D donned (put on) gloves, gathered graduate and alcohol prep wipe, released the clamp on the urinary drainage bag tubing, emptied the urine into the graduate, re-clamp the drainage bag tube, wiped the end of the tubing with an alcohol prep wipe, secured drainage tube into the holder, placed the urinary drainage bag directly onto the floor and emptied the graduate of urine into the toilet. ULP-D doffed (removed) gloves, without performing hand hygiene in between glove changes, donned gloves, applied Skin prep to R3's right heel blister. ULP-D doffed and donned gloves, without performing hand hygiene, assisted in applying R3's compression stocking to right leg. ULP-D doffed and donned gloves, without performing hand hygiene, applied sleeve to R3's left stump, and assisted with dressing R3's lower body with pants, and shoes. ULP-C doffed and donned gloves, without performing hand hygiene, handed R3 his dentures. R3 stood up and R3's urinary drainage tubing detached and ULP-D reconnected tubing without disinfecting connection ends with an alcohol prep wipe. ULP-D doffed and donned gloves, without performing hand hygiene, assisted R3 with his shirt and transferred R3 into his electric wheelchair and attached urinary drainage catheter bag into the cover attached to the wheelchair. ULP-D doffed and donned gloves and removed garbage's from R3's room and disposed the garbage in the soiled utility room. ULP-D doffed gloves and washed hands at the kitchen sink. ULP-D confirmed she did not perform hand hygiene in between glove changes, or disinfected urinary drainage tube when the	0 510		

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0 510	Continued From page 3 drainage tubing was reconnected. ULP-D confirmed she placed the urinary drainage bag directly on the floor and either should have placed it on a towel or hung it on the frame of the bed. On May 11, 2022, at 9:30 a.m., licensed assisted living director (LALD)-A stated it was the expectations of staff to perform hand hygiene in between glove changes. LALD-A further stated anytime the urinary drainage system was disconnected, the ends of the tubing should be disinfected with an alcohol wipe and the urinary drainage bag should not be placed directly onto the floor. The licensee's Standard Precautions (Universal Precautions) policy dated October 4, 2021, directed promptly after removal of gloves to wash hands. The licensee's written steps for Catheter-Emptying Drainage Bag dated January 6, 2015, directed to apply gloves, place a paper towel on the floor near catheter bag with graduate placed on a paper towel, drain urine into graduate, re-clamp tubing, wipe the end of tubing with an alcohol wipe, empty the graduate, remove gloves and wash hands. No further information was provided. TIME PERIOD 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	0 550		

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0 550	Continued From page 4 e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all 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) 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 a facility tour on May 9, 2022, at 9:50 a.m., the surveyor observed, with licensed assisted living director (LALD)-A, the main entrance and/or common areas lacked the required 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. On May 9, 2022, at 9:56 a.m., LALD-A confirmed the licensee's grievance procedure was not posted as required.	0 550		

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0 550	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (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	0 810		

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0 810	Continued From page 6 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop and maintain plans for fire safety and evacuation. This had the potential to directly affect all 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 10, 2022, between 10:00 a.m. and 11:00 a.m., survey staff toured the facility with maintenance (M)-B. During the facility tour, it was observed that the number and location of resident sleeping rooms were not legible on the evacuation maps posted in the facility. In an interview with the licensed assisted living director (LALD)-A, at approximately 12:45 p.m., they confirmed that the resident rooms needed to be more clearly identified on the evacuation maps. On May 10, 2022, at approximately 10:00 a.m., the LALD-A provided documents for review. Documents were reviewed by survey staff on May 10, 2022, between 11:00 a.m. and 12:15 p.m. The Fire Plan dated 07-01-2021 had not been developed and maintained for the facility location. 1. The plan references evacuation by stairs, which the facility does not have. 2. The fire alarm annunciator panel location was	0 810		

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0 810	Continued From page 7 blank within the plan. 3. The number and location of resident sleeping rooms were not legible on the evacuation map included with the plan. 4. Identification of unique or unusual resident needs for movement or evacuation was not included in the plan. 4. The plan failed to outline the required employee training frequency. The plan states that all employees shall be trained in fire safety and evacuation procedures upon hire and annually. On May 10, 2022, at approximately 12:15 p.m., the LALD-A provided copies of employee training records for review. The records showed that employees were trained on fire safety and evacuation plans upon hire with two additional onsite fire safety and evacuation training sessions scheduled annually. On May 10, 2022, at approximately 12:45 p.m., the LALD-A confirmed during an interview that the licensee failed to develop and maintain a fire safety and evacuation plan for this location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a	0 970		

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0 970	Continued From page 8 lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 11 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: On May 9, 2022, at 9:00 a.m., during the entrance conference, a copy of the licensee's assisted living contract was requested and provided. The assisted living contract included three clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Page 9, section 17. of the contract indicated the resident agreed the provider was not responsible for any loss or damage to resident's personal property due to any reason or cause, including theft, other than provider's own negligence. Page 11, section 22. of the contract indicated as an occupant of the community, resident assumed the risk for resident's own safety. The resident would	0 970		

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0 970	Continued From page 9 indemnify and hold harmless provider, its employees, officers, managers, owners, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of resident or resident's guests or agents. Page 11, section 24. of the contract indicated the provider was not liable to resident for any injury, death or property damage occurring in the apartment or provider's premises unless such injury, death or property damage occurs as the result of provider's own negligent acts or omissions, or those of its employees, officers, managers, owners, or agents. Provider is also not liable for any injury, death, or damage occurring as the result of resident's receipt of health-related, supportive, or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, resident agrees to hold provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on provider's premises. On May 11, 2022, at 9:58 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-F confirmed the same assisted living contract was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 10 (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. (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 observation, interview and record review, the licensee failed to ensure service plans were revised to reflect the current services provided for two of three residents (R3, R5), with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

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01640	Continued From page 11	01640		

than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

On May 9, 2022, at 9:00 a.m., during entrance conference, licensed assisted living director (LALD)-A stated the licensee's service plan was used for all residents.

R3
R3's diagnoses included diabetes with other circulatory complications, hypertensive heart disease (a condition caused by high blood pressure over a length a time), and congestive heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs).

R3's signed prescriber orders dated April 28, 2022, included Skin Prep (a liquid film that works as a skin barrier to protect the skin) twice a day to right heel blister.

On May 10, 2022, at 6:43 a.m., unlicensed personnel (ULP)-D was observed applying Skin Prep to R3's right heel blister.

R3's signed service plan dated February 10, 2022, lacked R3's treatment of applying Skin Prep twice a day to R3's right heel blister.

R5
R5's diagnoses included cerebral infarction (stroke), hypertension (high blood pressure), anxiety, and disorders of bone density and structure.

R5's signed service plan dated May 10, 2022, did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
01640	Continued From page 12 not indicate R5 received medication management services. R5's prescriber order dated May 7, 2022, included an order to crush medications unless otherwise indicated, and put in applesauce or pudding twice a day. On May 10, 2022, at 7:55 a.m., ULP-D was observed administering R5's morning medications which had been previously setup in a weekly medication planner (a plastic medication box with designated compartments for days and times). On May 10, 2022, at 1:57 p.m., licensed assisted living director (LALD)-A confirmed resident service plans should be updated to reflect current services each resident is receiving by the licensee. The licensee's service plan indicated if a resident's service needs change for any reason, the provider would revise the service plan to reflect such changes and would obtain resident's written approval of the new service plan with adjusted monthly service fee total to reflect the change in services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

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01730	Continued From page 13 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. (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.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

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01730	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for a resident to include all required content for one of one resident (R5) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 9, 2022, at 9:00 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to include medication setup. LALD-A further stated service plans were used for residents receiving services provided by the licensee and were updated with a change in service. R5's diagnoses included cerebral infarction (stroke), hypertension (high blood pressure), anxiety, and disorders of bone density and structure. R5's prescriber orders dated May 5, 2022, included medications to treat depression, hypertension, restless legs, osteoporosis, heart burn, cholesterol, low thyroid levels, and vitamins	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
01730	Continued From page 15 and supplements. R5's prescriber order dated May 7, 2022, included an order to crush medications unless otherwise indicated, and put in applesauce or pudding twice a day. Medications ordered not to crush included, levothyroxine, Omeprazole, oyster shell, vitamin D3, and gabapentin. R5's service plan dated May 10, 2022, lacked a service agreement to include a written statement of the medication management services R5 received by the licensee. R5's Medication Sheet for May 1, 2022, through May 15, 2022, indicated the licensee provided medication management services for R5 to include medication set up. R5's Medication Sheet for May 5, 2022, through May 10, 2022, indicated R5 received medication administration services. On May 10, 2022, at 7:55 a.m., ULP-D was observed administering R5's morning medications which had been previously setup in a weekly medication planner (a plastic medication box with designated compartments for days and times). On May 11, 2022, at 11:22 a.m., LALD-A confirmed R5's received medication management services to include medication set up, administration, and storage. LALD-D further confirmed resident service plans should reflect current services received by the licensee. The licensee's service plan indicated if a resident's service needs change for any reason, the provider would revise the service plan to reflect such changes and would obtain resident's written approval of the new service plan with	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
01730	Continued From page 16 adjusted monthly service fee total to reflect the change in services. The licensee's Development of the individualized medication management plan and individualized medication record-AL-MN policy dated August 1, 2022, indicated the RN was to develop and individualized medication management plan based on the nursing assessment for each resident needs or request of medication management services and the plan would be part of the resident's service plan. The plan further indicated, the licensed nurse would ensure each resident's individualized medication management plan would be kept up to date and consistent with prescriber's orders and the needs and preference of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=D	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.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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 17 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) prepared in writing specific instructions for one of one resident (R?) who received medication set up. 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: R5's diagnoses included cerebral infarction (stroke), hypertension (high blood pressure), anxiety, and disorders of bone density and structure. R5's prescriber order dated May 7, 2022, included an order to crush medications unless otherwise indicated, and put in applesauce or pudding twice a day. Medications ordered not to crush included, levothyroxine, Omeprazole, oyster shell, vitamin D3, and gabapentin. R5's service plan dated May 10, 2022, did not indicate R5 received medication management services. On May 10, 2022, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare R5's scheduled morning medications, which had been previously setup in a weekly medication	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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 18	01750		

planner (a plastic medication box with designated compartments for days and times). R5's medication planner had a sticky note on it with the name of the medications that were set up in the planner. R5's medication planner lacked a description of the medications, dosage, route, and times of administration and did not indicate which medications were not to be crushed. ULP-D confirmed R5's medication administration record (MAR) lacked a description of the medication to be able to identify what pills in the medication planner were not to be crushed. ULP-D took R5's 8:00 a.m., scheduled medications from the medications planner and crushed all the pills except for what ULP-D identified as oyster shell, levothyroxine and an Omeprazole capsule, and administered to R5. ULP-D stated she was not "100 percent sure" but had a good guess on identifying what medications were not to be crushed.

On May 11, 2022, at 11:22 a.m., LALD-A confirmed R5's medications were being set up in a medication planner. LALD-A confirmed R5's record lacked specific written instructions identifying what medications could not be crushed. LALD-A further confirmed R5's medication planner did not include the strength, dose, route, and time of administration.

The licensee's Medication Set Up and Documentation policy dated March 31, 2022, indicated each setup dose box would be labeled with the resident's name, medications, strength, dose, route, and time of administration.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 9, 2022, at 9:00 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided medication management services to include medication setup. R5's diagnoses included cerebral infarction (stroke), hypertension (high blood pressure), anxiety, and disorders of bone density and structure.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
01770	Continued From page 20 R5's prescriber order dated May 7, 2022, included an order to crush medications unless otherwise indicated, and put in applesauce or pudding twice a day. Medications ordered not to crush included, levothyroxine, Omeprazole, oyster shell, vitamin D3, and gabapentin. R5's service plan dated May 10, 2022, did not indicate R5 received medication management services. On May 10, 2022, at 7:55 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare R5's scheduled morning medications, which had been previously setup in a weekly medication planner (a plastic medication box with designated compartments for days and times). R5's medication planner had a sticky note on it with the name of the medications that were set up in the planner. R5's medication planner lacked a description of the medications, dosage, route, and times of administration and did not indicate which medications were not to be crushed. ULP-D confirmed R5's medication administration record (MAR) lacked a description of the medication to be able to identify what pills in the medication planner were not to be crushed. ULP-D took R5's 8:00 a.m., scheduled medications from the medications planner and crushed all the pills except for what ULP-D identified as oyster shell, levothyroxine and an Omeprazole capsule, and administered to R5. ULP-D stated she was not "100 percent sure" but had a good guess on identifying what medications were not to be crushed. On May 11, 2022, at 11:22 a.m., LALD-A confirmed R5's medications were temporarily being set up in a medication planner. LALD-A confirmed R5's medication planner lacked	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
01770	Continued From page 21 identification of the medications that could not be crushed and further confirmed the medication planner did not include the strengths, dose, route, and times the medications were to be administered. The licensee's Medication Set Up and Documentation dated March 31, 2022, indicated each setup dose box would be labeled with the resident's name, medications, strength, dose, route, and time of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to date time-sensitive medications with an expiration date for two of two residents (R4, R6) and failed to monitor for expired medications for one of two residents (R6). 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
01890	Continued From page 22	01890		

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).

Findings include:

On May 9, 2022, at 10:14 a.m., the surveyor observed the medication cart with unlicensed personnel (ULP)-D. ULP-D observed and confirmed the following:

R4
R4's Lantus insulin pen (a multiple dose pen shaped injector device for insulin administration) had a prescription label which indicated the date the pen had been opened and lacked when the insulin pen would expire.

R6
R6's opened bottle of Fluorometholone 0.1% ophthalmic suspension had a label with the date the eye drop had been opened and lacked the date the eye drop solution would expire. R6's opened bottle of Timolol Maleate ophthalmic solution 0.5% was opened April 5, 2022, and lacked the date the eye drop solution would expire. On May 9, 2022, at 10:14 a.m., ULP-D stated she goes by the expiration date printed on the medication bottles by the manufacturer and was not aware of expiration dates for time-sensitive medications.

On May 9, 2022, at 2:12 p.m., ULP-E confirmed R6 received Timolol eye drops twice a day and was past the 28 days of when the eye drop was opened.

On May 9, 2022, at 2:15 p.m. licensed assisted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
01890	Continued From page 23 living director (LALD)-A confirmed R6's Timolol eye drop was past the recommended 28 day use after opening and should be discarded. LALD-A confirmed time-sensitive medications should have the date the medication was opened and would expire. The manufacturer's instructions for Lantus insulin pens dated December 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Fluorometholone ophthalmic solution dated March 2015, indicated once the bottle was opened, store at room temperature and discard solution 30 days after it had been opened. The licensee's Medication Administration-AL policy dated April 29, 2021, indicated discard date stickers would be applied to vials, inhalers, eye drops indicating the date that the item is to be discarded. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

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01940	Continued From page 24 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 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 observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R3) receiving treatments with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
01940	Continued From page 25 limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 9, 2022, at 9:00 a.m., during entrance conference, licensed assisted living director (LALD)-A stated the licensee's service plan was used for all residents. R3's record lacked evidence of a written statement for service being provided to include Skin Prep twice a day to R3's right heel blister on R3's signed service plan dated February 10, 2022. R3's treatment plan lacked procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services. R3's diagnoses included diabetes with other circulatory complications, hypertensive heart disease (a condition caused by high blood pressure over a length a time), and congestive heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs). R3's signed prescriber orders dated April 28, 2022, included Skin Prep (a liquid film that works as a skin barrier to protect the skin) twice a day to right heel blister. R3's service checkoff list dated April 26, 2022, through May 9, 2022, indicated R3 received treatment services to include applying Skin Prep to blister on right leg heel twice a day. On May 10, 2022, at 6:43 a.m., the surveyor observed unlicensed personnel (ULP)-D applying Skin Prep to R3's right heel blister.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

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01940	Continued From page 26 On May 10, 2022, at 1:57 p.m., LALD-A confirmed R3's service plan lacked a written statement of treatment services to include treatment to R3's right heel blister and R3's treatment plan lacked procedures for notifying a registered nurse if problems arise. The licensee's Development of the individualized treatment or therapy management plan-AL dated August 1, 2021, indicated the RN would develop an individual treatment management plan based on the nursing assessment for each resident that needs or requests treatment services. The plan would be based off prescriber orders and the plan would be par of the resident's service plan. The policy further indicated, the RN or licensed nurse would ensure each resident's individual treatment management plan would be kept up to date. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02310 SS=G	144G.91 Subd. 4 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 acceptable health care, medical, or nursing standards for one of one	02310	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
02310	Continued From page 27 resident (R2) with bedrails who lacked a comprehensive bedrail assessment to include measurements of the bedrails to determine compliance with Food and Drug Administration (FDA) guidelines for bedrails. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 9, 2022, at 9:00 a.m., during entrance conference, licensed assisted living director (LALD)-A provided the surveyor with the facility matrix which indicated R2 had bedrails. LALD-A stated R2 had a bedrail assessment and measurements of the bedrails were completed and determined to be within FDA guidelines for bedrails. LALD-A further stated R2 was provided an explanation of risks and benefits for the use of bedrails. R2's diagnoses included mild cognitive impairment, pain in right shoulder, chronic fatigue, depression, and abnormalities in gait and mobility. R2's service agreement dated May 9, 2022, indicated R2 received the following services: medication management, bathing assistance, weekly laundry and housekeeping. On May 9, 2022, at 11:31 a.m., LALD-A provided	02310	Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20329	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

(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
02310	Continued From page 28 R2's MN-Device-Equipment assessment dated April 13, 2022, to the surveyor for review. LALD-A verified R2's bedrail assessment did not include documented measurements of the bedrails. LALD-A stated she would have to contact registered nurse (RN)- C who completed R2's assessment to find out if RN-C documented the bedrail measurements in R2's record. On May 9, 2022, at 1:45 p.m., the surveyor observed R2 had bilateral upper bedrails, in the upright position, securely attached to R2's hospital bed. On May 9, 2022, at 2:08 p.m., R2 stated she used the bedrails to help her get in and out of bed and family provided the hospital bed with the bedrails. On May 9, 2022, at 2:45 p.m., LALD-A spoke with RN-C via phone and confirmed RN-C did not document R2's bedrail measurements in R2's record. The FDA's "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MOOSE LAKE VILLAGE ASSISTED LI	4560 COUNTY HIGHWAY 61 MOOSE LAKE, MN 55767

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02310	Continued From page 29 indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches. The licensee's Physical Device Safety-Side Rails policy revised January 9, 2020, indicated due to the risk of injury related to the use of physical devices, such devices may only be used after an assessment had been completed to determine the risks and benefits of the use. The resident/family member must be educated regarding the risks and benefits of physical devices. Physical devices must be reviewed for safety and used according to the manufacturer recommendations. Physical devices include, but not limited to, siderails (half or full); grab bars, halo bars, and positioning poles. Maintenance staff would inspect the bed and mattress monthly for zone safety on a monthly basis per the Mattress/bed inspection assisted living policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days Immediacy is removed as confirmed by a review of plan of correction by evaluation supervisor on May 9, 2022, however noncompliance remains at a scope and severity of G.	02310		

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

Type: Full
Date: *05/10/22*
Time: 10:00:00
Report: 1027221050

Food and Beverage Establishment Inspection Report

Location:
Moose Lake Village Assisted Li
4560 County Highway 61
Moose Lake, MN55767
Carlton County, 09

Establishment Info:
ID #: 0038607
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183519415
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

THERE WERE NO TEST STRIPS FOR MEASURING QUATERNARY AMMONIA SANITIZER IN RECEIVING KITCHEN AT TIME OF INSPECTION. MANAGER PROVIDED TEST STRIPS FROM HOSPITAL KITCHEN. COS

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: COTTAGE CHEESE
Violation Issued: No

Type: Full
Date: *05/10/22*
Time: 10:00:00
Report: 1027221050
Moose Lake Village Assisted Li

Food and Beverage Establishment Inspection Report

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

KITCHEN IS ONLY USED AS A RECEIVING KITCHEN. ALL FOOD IS PREPARED IN HOSPITAL KITCHEN THAT IS IN ADJACENT BUILDING AND INSPECTED BY ANOTHER UNIT.

DISCUSSED COOK TEMPS, SANITIZER STRENGTHS, EMPLOYEE ILLNESS AND EXCLUSIONS, AND GLOVE AND UTENSIL USE TO AVOID BARE HAND CONTACT WITH READY TO EAT FOODS WITH MANAGER. MANAGER STATED ALL FOODS ARE COOKED TO THE REQUIRED TEMPERATURE AND ALL EGGS THAT ARE USED ARE PASTEURIZED.

DISH MACHINE IN RECEIVING KITCHEN WAS OUT OF ORDER AT TIME OF INSPECTION. MANAGER STATED THAT ALL DISHES WERE BEING DONE IN DISH MACHINE OF HOSPITAL KITCHEN.

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

I acknowledge receipt of the MN Department of Health inspection report number 1027221050 of 05/10/22.

Certified Food Protection Manager: MARK CARDINAL

Certification Number: FM107261 Expires: 08/05/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
MARK CARDINAL
MANAGER

Signed: Ian Harrison
Ian H

651-201-4500
health.foodlodging@state.mn.us

Report #: 1027221050

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	05/10/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Moose Lake Village Assisted Li	4560 County Highway 61	Moose Lake, MN	55767	2183519415

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038607		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/12/22

Inspector (Signature) Dan Harrison