Electronically Delivered

March 8, 2024

Licensee
Prairie Pines Community
903 Prairie Pines Drive
Fosston, MN 56542

RE: Project Number(s) SL30394015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 28, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 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
	30394	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE PINES COMMUNITY	903 PRAIRIE PINES DRIVE FOSSTON, MN 56542

(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: SL30394015 On Febuary 26, 2024, through Febuary 28, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 19 residents receiving services under the Assisted Living license.	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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 26, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

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0 650	Continued From page 2 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for two of four employees (clinical nurse supervisor (CNS-C), 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: CNS-C CNS-C was hired on December 12, 2022, to provide direct care and services to the licensee's	0 650		

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0 650	Continued From page 3 residents and oversight of the licensee's employees. On February 26, 2024, at 9:59 a.m., during the entrance conference, CNS-C identified herself as the CNS for the facility. CNS-C's employee record did not include documentation of all the required training to include: -annual review of provider's policies and procedures. ULP-D ULP-D was hired on November 20, 2023, to provide direct care and services to the licensee's residents. ULP-D's employee record did not include documentation of all the required training to include: -annual review of provider's policies and procedures. On February 27, 2024, at 5:58 a.m., the surveyor observed ULP-D giving a shift-to-shift report to ULP-E. On February 26, 2024, at 3:27 p.m., LALD-A stated there was no evidence of a review of the provider's policies and procedures in any of the licensee's employee records for annual training. LALD-A said employees did review the provide's policies and procedures yearly. The licensee's Employment Records- Release of Employment Information policy dated May 14, 2012, noted employee personnel records were maintained in the Human Resources department. As required by law, some records pertaining to	0 650		

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0 650	Continued From page 4 employees are maintained in separate files related to medical issues and internal investigations. The licensee's Assisted Living Orientation Training-Competency of Staff policy dated September 20, 2023, noted annual training must include: -review of the facility's [policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. Training in Dementia Care: all direct care staff and supervisors providing direct services must demonstrate an understanding of the training. The assisted living facility must meet the following training requirements: -supervisor of direst-care staff must have at least eight hours of initial training on topics specified under with 120 working hours of the employment start date and must have at least two hours of training on topics related to dementia care annually -direct-care employees must have completed at least eight hours of finial training on topics specified with 160 hours of the employment start date and must have at least two hours of training annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	01290		

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01290	Continued From page 5 the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for one of four employees (unlicensed personnel/ULP-B). 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-B was hired on January 31, 2008, and had begun working under the assisted living license effective August 1, 2021, to provide direct care services to the licensee's residents. On February 26, 2024, at 11:45 a.m., the	01290		

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01290	Continued From page 6 surveyor observed ULP-B administer medication to R6. ULP-B's record lacked documentation of a background study affiliated with the facility's license. ULP-B's record included a background study for another license, 416, which was under the same ownership. On February 27, 2024, at 10:47 a.m., licensed assisted living director (LALD)-A stated "we" (assisted living) are on a list with several entities (nursing home, clinic, etc) and are part of First Care Medical Services. LALD-A added she wished she had more involvement with background studies. LALD-A stated the provider had not completed a background study affiliated with the license for ULP-B. The licensee's Assisted Living (AL) Employee Background Studies policy dated September 20, 2023, noted using the MN DHS (Minnesota Department of Human Services) Net Study online program, facilities would work with human resources (HR) to initiate a background study on all employees being considered for hire. No further information was provided. TIME PERIOD FOR CORRECTION: two (2) days	01290		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

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01650	Continued From page 7 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01650		

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01650	Continued From page 8 The findings include: R2's diagnoses include type 1 diabetes, high blood pressure (HTN), and chronic diastolic heart failure (main heart pumping chamber becomes stiff and unable to fill properly). R2's service plan dated February 9, 2024, indicated R2 required assistance with medication administration and/or reminders, medication set-up and/or prep of medication, skin care, laundry, fingernail/ toenail care, vital sign monitoring, and blood sugar testing. On February 26, 2024, at 11:36 a.m., the surveyor observed unlicensed personnel (ULP)-B check R2's blood sugar level. R2's service plan lacked: -the methods of monitoring assessments of residents. On February 26, 2024, at 12:55 p.m., R2's service plan was reviewed with clinical nurse supervisor (CNS)-C. CNS-C confirmed R2's service plan did not include the above required information. In addition, CNS-C stated all of the service plans used were the same and all would be missing the required information. The licensee's service plan content policy was requested however, on September 28, 2024, at 7:39 a.m., licensed assisted living director (LALD)-A replied, "our service plans are directly tied to the electronic assessment and completed within Matrix (computer system.)" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01650		

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01650	Continued From page 9 (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment for one of three residents (R2) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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's diagnoses include type 1 diabetes, high blood pressure (HTN), and chronic diastolic heart failure (main heart pumping chamber becomes stiff and unable to fill properly). R2's service plan dated February 9, 2024, indicated R2 required assistance with medication	01710		

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01710	Continued From page 10 administration and/or reminders, medication set-up and/or prep of medication, and blood sugar testing. In addition, R2's service plan dated February 9, 2024, included R2's medication assistance/assessment and individualized medication plan: -can state the name of medication: needs assistance -knows what each medication is used for: needs assistance -can read the bottle for name and dosage: needs assistance -remembers to take each medication on time: needs assistance -can report any symptoms and/or adverse effects: needs assistance -can open any containers: needs assistance -resident has scheduled medications that are set up by licensed nurse weekly and PRN (as desired or as needed). She has two PRN medications, one that she manages herself (Diclofenac gel for knee pain) and one administered per staff (Tylenol). On February 27, 2024, at 6:24 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R2's morning medication and check R2's blood sugar level using correct technique. The surveyor observed an opened bottle of glucose tablets on a side table located next to R2's recliner. Directly after the above observation, R2 stated she "had" to use them (glucose tablets) "again last night." On February 27, 2024, at 10:53 a.m., clinical nurse supervisor (CNS)-C stated she recently reviewed R2's medication's adding she did not update R2's medication assessment and	01710		

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01710	Continued From page 11 medication plan as required. The licensee's AL (assisted living) Initial and Ongoing Evaluation of Resident's Needs policy dated November 21, 2022, noted the licensed assisted living facility (LALF) conducted a review for current resident to establish need for services on an ongoing basis. When services were needed the registered nurse would conduct nursing assessments to include: -providing verbal or visual reminders to the resident to take regularly scheduled medication, which included brings the resident previously set up medication, medication in original containers, or liquid or food to accompany the medication. The Uniform Assessment Tool addressed: -a review of medication according to Minnesota Statues, section 144G.71, subdivision 2, including prescriptions, over-the- counter medication, and supplements, and for each: -the reason taken -any side effects, contraindications, allergic or adverse reactions, and actions to address these issues -dosage -frequency of use -route administered or taken -any difficulties the resident faces in taking the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated	01750		

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01750	Continued From page 12 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 the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses include chronic cough, and dyspnea (difficult or labored breathing), and chronic bronchitis (productive cough of more than three months occurring within a span of two years.) R3's service plan dated February 9, 2024, included:	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30394	A. BUILDING: _____ B. WING _____	02/28/2024

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01750	Continued From page 13 -medication administration and/or reminders: three times daily R3's medication administration record (MAR) dated February 1, 2024, through February 27, 2024, noted: -albuterol sulfate HFA aerosol inhaler (prevent and treat wheezing and shortness of breath (SOB); 90 micrograms (mcg)/actuation: amount to administer: two puffs into lungs: inhalation. Give two puffs as needed every four hours as needed (PRN,) instruct resident to release breath, place lips around mouth of inhaler, then take in a full breath as the inhaler is depressed and hold up to ten seconds as able. Instruct the resident to keep lips tightly around mouthpiece and take an additional two-three breaths. R3's prescriber orders dated February 8, 2024, included: -albuterol MDI (metered dose inhaler) every four hours PRN for SOB. On February 27, 2024, at 8:56 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare and administer R3's morning medication using correct technique. R3's wife asked ULP-E to give R3 his inhaler. ULP-E asked R3 if he wanted/needed his PRN albuterol sulfate aerosol 90 mcg inhaler. R3 declined the offer of the inhaler. Directly after the above observation, ULP-E stated R3's MAR did not instruct staff to shake inhaler before use, adding her husband had an inhaler so she knew to shake inhaler prior to use. ULP-E said R3's MAR did not include instructions to use a spacer, adding a spacer is used. On February 27, 2024, at 11:10 a.m., clinical nurse supervisor (CNS)-C stated she forgot to	01750		

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01750	Continued From page 14 add the work spacer to R3's MAR, adding she did education on use of spacers. CNS-C confirmed R3's record did not instruct ULPs to shake prior to use. The manufacturer's instructions for albuterol sulfate inhaler dated September 2017, noted shake the inhaler well before each use. Check inside the mouthpiece for objects before use. Make sure the canister is fully inserted into the actuator. Breathe out as fully as you comfortably can through your mouth. Hold the inhaler in the upright position with the mouthpiece pointing towards you and place the mouthpiece fully into the mouth, close your lips around the mouthpiece. Hold your breath as long as you conformable can, up to ten seconds. Remove the inhaler from your mouth, and then breathe out. The licensee's Assisted Living Medication and Treatment Management policy dated September 20, 2023, noted the RN developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding substances that are prescribed for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication was secured in a locked area for two of four residents, (R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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: R6 R6's diagnoses included gastro-esophageal reflux disease (GERD) without esophagitis (stomach acid flows back up the esophagus (swallowing tube) into the larynx (voice box) and throat. R6's service plan dated December 15, 2023, included R6's medication assistance/assessment and individualized medication/treatment plan which indicated medications were stored in a locked cabinet in R6's room. On February 27, 2024, at 6:36 a.m., the surveyor observed unlicensed personnel (ULP)-E unlock a cabinet in R6's room and removed a black box that contained R6's medication. ULP-E prepared R6's medication and administered R6's morning medication. The surveyor observed a container of	01880		

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01880	Continued From page 16 opened Tums extra strength (heartburn, indigestion and upset stomach caused by too much stomach acid) sitting on a side table positioned next to R6's recliner. R7 R7's diagnoses include GERD without esophagitis. R7's service plan dated February 13, 2024, included R7's medication assistance/assessment and individualized medication/treatment plan which indicated medications were stored in a locked medication care and in a locked box in R7's apartment. On February 27, 2024, at 7:07 a.m., the surveyor observed ULP-E remove a locked black medication box from a cabinet and administer R7's morning medication. The surveyor observed an opened bottle of Tums extra strength and an unopened bottle of Tums on R7's microwave. On February 27, 2024, at 11:03 a.m., clinical nurse supervisor (CNS)-C stated she was not aware of Tums use for R6 and R7. CNS-C confirmed Tums should not have been available for R6 and R7 and stored in their rooms unsecured. The licensee's AL (assisted living) Medication and Treatment Management policy dated September 20, 2023, noted the LAF (licensed assisted living facility) would verify all medications were up-to date- and stored as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and 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 each resident and documented those instructions for one of one resident (R2) receiving blood glucose monitoring and for one of three residents (R2) with compression hose (TEDs) application. 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	01950		

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	30394	A. BUILDING: _____ B. WING _____	02/28/2024

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01950	Continued From page 18 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's diagnoses include type 1 diabetes, high blood pressure (HTN), and chronic diastolic heart failure (main heart pumping chamber becomes stiff and unable to fill properly). R2's service plan dated February 9, 2024, indicated R2 required assistance with blood sugar testing: -staff does all performance of blood sugar testing, checks, reads, dosing and/ or records. Staff maintains supplies -management of continuous glucose monitoring system. Resident has a Freestyle Libre 2 (measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm) in place. -application of TED socks on in the morning and off in the evening. Resident refuses at times, on days that she wears them, staff will assist with washing them at bedtime and hanging to dry. BLOOD GLUCOSE MONITORING R2's February 1, 2024, through February 26, 2024, medication administration (MAR) record included: -check blood sugar four times daily. Notify nurse if blood sugar is less than 60 or greater than 400 or if symptomatic. Check blood sugar tour times daily using the Freestyle Libre. Hold the monitor to the sensor, document the blood sugar result. R2's prescriber order dated June 12, 2023, included: -check blood sugar four times daily. Notify nurse	01950		

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01950	Continued From page 19 if blood sugar is less than 60 or greater than 400 or if symptomatic. Check blood sugar four times daily using the Freestyle Libre. Hold the monitor to the sensor, document the blood sugar result. Four times a daily: 7:45 a.m., 11:45 a.m., 5:00 p.m., 8:00 p.m. On February 27, 2024, at 915 a.m., the surveyor observed unlicensed personnel (ULP)-E go to R2's room to administer R2's morning insulin. ULP-E stated she "knew" R2's blood sugar would be high as she had eaten breakfast. The Libre meter was held up to R2's arm but the meter would not read R2's blood sugar. ULP-E stated we will try again in a few minutes, "you (R2) were away from the meter for a while" (for breakfast/ meter was not reading). ULP-E attempted one more time to use R2's Libre testing system and was unsuccessful. ULP-E set out alcohol pads, removed a blood sugar meter out of a case, inserted a testing strip into the blood sugar meter, prepared a lancet, cleaned the side of one of R2's fingers and used the lancet to collect a drop of blood which was placed onto the testing strip to collect a blood sugar reading of 285. On February 27, 2024, at 10:52 a.m., clinical nurse supervisor (CNS)-C and licensed assisted living director (LALD)-A stated R2's record should have included using finger stick method of checking blood sugar level if and when issues were found with Libre system. TED APPLICATION R2's service's dated February 9, 2024, included application of TED socks on in the morning and off in the evening. Resident refuses at times, on days that she wears them, staff will assist with washing them at bedtime and hanging to dry.	01950		

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01950	Continued From page 20 R2's prescriber order dated October 9, 2023, included compression stockings: on during the day. Remove once a day to let skin breathe, twice a day 5:30 a.m. -10:00 a.m., 6:30 p.m. -10:00 p.m. On February 27, 2024, at approximately 6:30 a.m., the surveyor observed a pair of TEDs laying across R2's kitchen sink. ULP-E asked R2 if R2 had another pair of TEDs she wanted ULP-E to apply. R2 stated she did not have another pair of TEDS. ULP-E took the TEDs into the bathroom to hang to dry. On February 27, 2024, at 10:53 a.m., CNS-C stated R2's record did not include when and what to report to nursing regarding R2's TEDs as required. The licensee's AL (assisted living) Treatment and Therapy Management policy dated September 20, 2023, noted the facility was able to provide, would develop and maintain a current individualized treatment and therapy management record for each resident which must contain: -documentation of specific resident instructions relating to the treatments or therapy administration will be on the treatment documentation form -procedures for notifying a registered nurse or appropriate licensed health profession when a problem arose with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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02310	Continued From page 21	02310		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards with an assistive device (consumer bed rail), for two of two residents (R6, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R6 R6's diagnoses include hypertension (high blood pressure/HTN), insomnia, anxiety disorder, dizziness, and giddiness (sensation of whirling and a tendency to fall or stagger.) On February 27, 2024, at 6:36 a.m., the surveyor observed unlicensed personnel (ULP)-E enter R6's bedroom and make R6's bed. The surveyor	02310		

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02310	Continued From page 22 observed a consumer bed rail positioned on the side of the bed nearest the door in R6's room. ULP-E stated R6 used the bedrail to turn over, adding R6 did not use the rail every day, "depending on the day." R6's Entrapment Evaluation & Consent form dated January 11, 2024, noted: -reason for potential/current use of bed rail: positioning assistance -physical/functional pre-disposing factors: weakness -safety/security pre-disposing factors: resident uses rail to pull herself up to a sitting position in bed and hold onto getting out of bed recommendations: partial rail- head of bed. Residents left side, when in bed -bed mobility- bed rail will assist resident to be active to the highest level of independence in the following areas: pulling self from laying to sitting position, transfers: aid in safe exiting from bed -if a bed rail and/or transfer aid is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements: -assess the resident for risk of entrapment from bed rails prior to installation -ensure that the bed's dimensions are appropriate for the resident's size and weight -follow the manufacturers' recommendations and specifications for installing and maintaining bed rails, if available -follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. If unable contact resident and/or resident representative, request made to: blank -including the risk of significant injury and/or entrapment have been reviewed with the resident and/or resident representative -bed rail was installed by maintenance personnel	02310		

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02310	Continued From page 23 and manufacturer's guidelines. Resident was educated on the risks of using a bed rail. R4 R4's diagnoses include HTN, insomnia, major depressive disorder, and osteoarthritis. On February 27, 2024, at 6:18 a.m., the surveyor observed ULP-E administer R4's morning medication using correct technique. The surveyor observed a consumer bed rail securely attached to R4's bed with two straps. R4 stated she does not get out of bed without using the bed rail. R4's Entrapment Evaluation & Consent form dated September 7, 2023, noted: -reason for potential/current use of bed rail: family request, positioning assistance -physical/functional pre-disposing factors: weakness -safety/security pre-disposing factors: blank -cognition/sensory pre-disposing factors: none of the above recommendations: partial rail, head of the bed, resident's right side, when in bed -bed mobility- bed rail will assist to achieve the highest level of independence in the following areas: pulling self from laying to sitting position and transfers: aid in safe exiting from bed -if a bed rail and/or transfer aid is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements: -assess the resident for risk of entrapment from bed rails prior to installation -ensure that the bed's dimensions are appropriate for the resident's size and weight -follow the manufacturers' recommendations and specifications for installing and maintaining bed rails, if available	02310		

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02310	Continued From page 24 -risk of bed rails use, including the risk of significant injury and/or entrapment have been reviewed with the resident and/or resident representative, reviewed with resident and her daughter -bed rail was installed by maintenance personnel and manufacturer's guidelines. Resident was educated on the risks of using a bed rail. On February 27, 2024, at 10:59 a.m., clinical nurse supervisor (CNS)-C reviewed R6 and R4's bedrail assessments and confirmed their records did not contain checking for consumer bedrail recalls. CNS-C showed the surveyor an undated piece of paper "cheat sheet" she had for bedrail assessments which included: Quarterly assessment: -check bedrail recall site (if applicable) and document. CNS-C added she knew about checking for bedrails from Leading Age (non-profit aging service.) CNS-C confirmed documentation regarding checking for bed rail recall was not in any of the consumer bedrail assessments for the licensee's residents. The licensee's AL (assisted living) Restraint policy dated September 20, 2023, noted the RN (registered nurse) would assess to assure the device did not restrict resident movement. Consumer Bed Rails: -the LALF (licensed assisted living facility) would refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. If manufacture's guidelines were not available, the LALF was unable to assess and determine if the portable bed rail being used appropriately and installed properly and this results in an imminent safety risk for the resident -the LALF the bed rail was securely attached -the LALF would assess the individual upon	02310		

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02310	Continued From page 25 admit, and every 90 days to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls if a bed rail was used -any documentation regarding the use of a person bed rail would be documented in the resident's electronic chart. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated February 20, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation - Any necessary information related to interventions to mitigate safety risk or negotiated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30394	A. BUILDING: _____ B. WING _____	02/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRAIRIE PINES COMMUNITY	903 PRAIRIE PINES DRIVE FOSSTON, MN 56542

(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 26 risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St. Paul, MN, 55164
218-332-5150

Type: Full
Date: *02/26/24*
Time: 13:43:44
Report: 1042241029

Food and Beverage Establishment Inspection Report

Location:
Prairie Pines Community
903 Prairie Pines Drive
Fosston, MN56542
Polk County, 60

Establishment Info:
ID #: 0037905
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184357630
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.

4-200 Equipment Design and Construction

4-202.11 ***** Priority 2 *****

MN Rule 4626.0515 Discontinue use of multi-use food-contact surfaces that are not smooth, free of breaks, open seams, cracks, chips, pits and other imperfections and that are not accessible for cleaning or inspection.

COUNTERTOPS NEED TO BE COMPLETELY SEALED/COVERED WITHOUT CHIPS, CRACKS, OPEN SEAMS, PITS, BREAKS, AND OTHER IMPERFECTIONS. FIX FLOORBOARDS BY STEAMTABLE WHERE SEAMS ARE OPEN/SEPARATED.

Comply By: 02/27/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 100ppm at Degrees Fahrenheit
Location: Sanitizer Bottle (Properly Labeled)
Violation Issued: No

Hot Water: = at 174.6 Degrees Fahrenheit
Location: Hot water sanitizer- Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit - Location: Chicken Noodle Soup
Violation Issued: No

Process/Item: Hot Holding
Temperature: 150.2 Degrees Fahrenheit - Location: Black Beans
Violation Issued: No

Type: Full
Date: *02/26/24*
Time: 13:43:44
Report: 1042241029
Prairie Pines Community

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 152.6 Degrees Fahrenheit - Location: Beef
Violation Issued: No

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

See order for Equipment Design and Construction 4-202.11. Breaks can lead to absorption of fluids and create degradation of facilities if not properly addressed.

Same-Day Service Kitchen. If baked goods include cake/breads made with dairy and/or eggs, they should be used/consumed on the same day. Cookies are exempt from this rule and may be served again. Any toppings/frostings of pastries made with dairy and/or eggs for cakes, breads, or cookies require consumption or use on same day per this 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 1042241029 of 02/26/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Signed:_____
Establishment Representative

Signed:_____
Tyler Pyle
Environmental Health Specialist
Fergus Falls Area Office
tyler.pyle@state.mn.us

Report #: 1042241029

Food Establishment Inspection Report

MN Department of Health
Food Pools and Lodging Services
PO Box 64975
St. Paul, MN, 55164

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 02/26/24
Time In 13:43:44
Time Out

Prairie Pines Community	Address	City/State	Zip Code	Telephone
	903 Prairie Pines Drive	Fosston, MN	56542	2184357630

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037905		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	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
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:** 02/27/24

Inspector (Signature) TJP