Electronically Delivered

June 10, 2025

Licensee
Lifestone Health Care Inc
319 7th Street
Proctor, MN 55810

RE: Project Number(s) SL32149016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 30, 2025, 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

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
	32149	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTONE HEALTH CARE INC	319 7TH STREET PROCTOR, MN 55810

(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 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: SL32149016 On April 28, 2025, through April 30, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents receiving services under the Assisted Living Facility 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 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 29, 2025, 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	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This had the potential to affect all residents.	0 920		

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0 920	Continued From page 4 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2's start of services was September 7, 2016, under the comprehensive home care license and then under the assisted living license beginning August 1, 2021. R2's diagnoses included cerebral aneurysm (bulge in weak area of a blood vessel in or around brain) /subarachnoid hemorrhage (brain bleed), seizures, depression, edema, heartburn, constipation, and hypothyroidism. R2's Individual Service/Care Plan dated April 10, 2025, indicated R2 received services which included medication administration, bathing, hygiene, dressing, telephone use, food preparation, eating, mobility, continence care, housekeeping, laundry, and orientation. R2's record did not include a service plan. On April 29, 2025, at 12:07 p.m., the surveyor observed unlicensed personnel (ULP)-B use a food processor to prepare R2's noon meal. R2's Assisted Living Services and Housing Contract Agreement dated August 4, 2021, lacked the following content: -a disclosure of the facility's ability to provide specialized diets.	0 920		

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0 920	Continued From page 5 On April 30, 2025, at 8:16 a.m., R2's contract was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she [LALD/CNS-A] had a different contract that had been used in the past at the facility, which had been updated from the last survey. LALD/CNS-A stated the licensee was working on yet another updated contract. LALD/CNS-A stated she could "show" the surveyor an updated contract that had been used however all of the residents with the updated contract had been discharged. LALD/CNS-A confirmed all of the current resident's records did not include an updated contract as required. LALD/CNS-A stated she was not aware that the licensee needed to have new contracts signed by the residents/resident's representatives. LALD/CNS-A stated she "thought" she needed to use a different (updated) contract going forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of	0 930		

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0 930	Continued From page 6 residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R2). This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included cerebral aneurysm (bulge in weak area of a blood vessel in or around brain) /subarachnoid hemorrhage (brain bleed), seizures, depression, edema, heartburn, constipation, and hypothyroidism. R2's Individual Service/Care Plan dated April 10, 2025, indicated R2 received services which included medication administration, bathing,	0 930		

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0 930	Continued From page 7 hygiene, dressing, telephone use, food preparation, eating, mobility, continence care, housekeeping, laundry, and orientation. R2's record did not include a service plan. On April 29, 2025, at 12:13 p.m., the surveyor observed unlicensed personnel (ULP)-B place medication into R2's mouth and ask R2 to chew the medication. R2's Assisted Living Services and Housing Contract Agreement dated August 4, 2021, lacked the following required information: - regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer. On April 30, 2025, at 8:16 a.m., R2's contract was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she (LALD/CNS-A) had a different contract that had been used in the past at the facility, which had been updated from the last survey. LALD/CNS-A stated the licensee was working on yet another updated contract. LALD/CNS-A stated she could "show" the surveyor an updated contract that had been used however all of the residents with the updated contract had been discharged. LALD/CNS-A confirmed all of the current resident's records did not include an updated contract as required. LALD/CNS-A stated she was not aware that the licensee needed to have new contracts signed by the residents/resident's representatives. LALD/CNS-A stated she "thought" she needed to use a different (updated) contract going forward. No further information was provided.	0 930		

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0 930	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 970 SS=C	144G.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 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 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 the potential to affect a large portion or all the residents). The findings include: R2's start of services was September 7, 2016, under the comprehensive home care license and then under the assisted living license beginning	0 970		

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0 970	Continued From page 9 August 1, 2021. R2's diagnoses included cerebral aneurysm (bulge in weak area of a blood vessel in or around brain) /subarachnoid hemorrhage (brain bleed), seizures, depression, edema, heartburn, constipation, and hypothyroidism. R2's Individual Service/Care Plan dated April 10, 2025, indicated R2 received services which included medication administration, bathing, hygiene, dressing, telephone use, food preparation, eating, mobility, continence care, housekeeping, laundry, and orientation. R2's record did not include a service plan. R2's Assisted Living Services and Housing Contract Agreement dated August 4, 2021, included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Page 6, section M. under II. The Company makes no representations or guarantees that the Company is secure from theft or and other criminal act perpetrated by any other Client or person; therefore, the Company recommends that valuables, including but not limited to, jewelry and large amounts of money, not be brought into the Company. If the Client chooses to bring in such valuables, Client is doing so at own risk and the Company will not be responsible for any theft or loss of these items. On April 30, 2025, at 8:16 a.m., R2's contract was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she (LALD/CNS-A) had a different contract that had been used in the past at the facility, which had been updated from the	0 970		

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0 970	Continued From page 10 last survey. LALD/CNS-A stated the licensee was working on yet another updated contract. LALD/CNS-A stated she could "show" the surveyor an updated contract that had been used however all of the residents with the updated contract had been discharged. LALD/CNS-A confirmed all of the current resident's records did not include an updated contract as required. LALD/CNS-A stated she was not aware that the licensee needed to have new contracts signed by the residents/resident's representatives. LALD/CNS-A stated she "thought" she needed to use a different (updated) contract going forward. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	01060		

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01060	Continued From page 11 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01060		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTONE HEALTH CARE INC	319 7TH STREET PROCTOR, MN 55810

(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
01060	Continued From page 12 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 28, 2025, at 10:55 a.m., during the entrance conference licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the current census was four residents. LALD/CNS-A stated there had been five residents at the facility, however one resident (R1) had been sent into the clinic for medication review. LALD/CNS-A stated when R1 was at the clinic, R1 was sent to the emergency department (ED). LALD/CNS-A stated R1 had been "fine" when he left the facility. LALD/CNS-A stated R1 had not returned to the facility "yet". LALD/CNS-A stated she forgot to complete the emergency relocation paperwork. LALD/CNS-A stated, "I have always done that [completed required paperwork]; I don't know why I forgot." R1's diagnosis included chronic obstructive pulmonary disease (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), oxygen dependence, tachycardia (fast heartbeat), and hypertension (HTN-high blood pressure). R1's service plan dated May 28, 2020, indicated R1 received the following services: meals, ADL assistance (activities of daily living), home management (housekeeping, laundry), cueing, pulse monitoring, and housekeeping services. R1's Client (resident) Individual Medication	01060		

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01060	Continued From page 13 Management Plan dated March 15, 2024, indicated R1 received medication administration by agency (licensee) staff. R1's Client Treatment or Therapy Management Plan dated August 11, 2024, indicated R1 oxygen administration daily. R1's Care Coordination Note dated April 21, 2025, included: - spoke with (name) of nurse. Called to inform "us" (licensee) that client was in the ER (room). The clinic he was at sent him in due to oxygen of 55% room air.... They (ER) will admit and treat for pneumonia and COPD exacerbation. R1's Care Coordination Note dated April 23, 2025, included: - D/C (discharge) is pending. Client doing well. Treating for COPD exacerbation. R1's record lacked a written notice that contained, at a minimum: - the name and contact information for the location to which the resident had been relocated and any new service provider - contact information for the OOLTC - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. The licensee's Emergency Relocation policy dated September 27, 2022, noted in the event of	01060		

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01060	Continued From page 14 an emergency relocation, the facility must provide a written notice that contained, at a minimum: - the reason for the relocation - the name and contact information for the location to which the resident had been relocated and any new service provider - contact information for the Office of Ombudsman for Long-Term Care - if know and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently know - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal. The facility would provide contact information for the agency to which the resident my submit an appeal. The notice required under paragraph (b) must be delivered as soon as practice to: - the resident, legal representative, and designated representative - for resident who receive home and community-based waiver services, the resident's case manager, and - the Office of Ombudsman for Long-Term Care if the resident has been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed	01420		

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01420	Continued From page 15 personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. 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) provided written instructions in the resident's record for delegated tasks provided by unlicensed personnel (ULP) for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included cerebral aneurysm (bulge in weak area of a blood vessel in or around brain) /subarachnoid hemorrhage (brain bleed), seizures, paraplegia (type of paralysis that	01420		

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01420	Continued From page 16 affects the lower half of the body), depression, edema, heartburn, and constipation. R2's Individual Service/Care Plan dated April 10, 2025, included: - supervise with eating (do not leave unattended) provide physical assistance as needed - puree all foods and snacks with food processor/blender - full assistance with wheelchair - tilt (wheelchair) about 15 degrees to prevent falls. R2's record did not include a service plan. R2's comprehensive nursing assessment dated April 23, 2025, included: - nutrition: diet, pureed, dysphasia (difficulty swallowing) - musculoskeletal: impaired, wheelchair. On April 29, 2025, at 11:49 a.m., the surveyor observed unlicensed personnel (ULP)-B take R2 to R2's room and check R2's brief. R2 was seated in a tilt-n-space chair (wheelchair that allowed the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure). ULP-B stated, "you (R2) have been sitting straight up for a while, while you are sitting here I am going to set you back a little here, how does that feel?" On April 29, 2025, at 12:07 p.m., the surveyor observed ULP-B use a food processor to prepare R2's noon meal. ULP-B took a medication cup to R2, tilted R2's chair into a more upright position and gave R2 the medication from the medication cup. ULP-B asked R2 to chew the medication.	01420		

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01420	Continued From page 17 R2's record lacked to include complete instructions for R2's tilt-n-space wheelchair as required, to adjust R2's wheelchair while eating. On April 29, 2025, at 1:22 p.m., R2's record was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated complete instructions for R2's tilt-n-space wheelchair were not in R2's record. The licensee's Delegation of Assisted Living Services policy date September 22, 2027 (sic), noted a registered nurse (RN) or licensed health professional at the facility my delegate tasks the RN or licensed health professional would document instructions for the delegated task in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01420		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in	01560		

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01560	Continued From page 18 written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 30, 2025, at 8:16 a.m., R2's record was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she did not have a description of the dementia training program, the categories of employees trained, the frequency of training, and the basic topics covered, in written or electronic form to consumers. LALD/CNS-A stated that information would be in the new contract which was in process. LALD/CNS-A then stated she "thought" maybe residents were given the information. The surveyor asked LALD/CNS-A to send the information, if located, to the	01560		

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01560	Continued From page 19 surveyor. The surveyor did not received the above listed information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01620		

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01620	Continued From page 20 review, the licensee failed to ensure a registered nurse (RN) conducted assessments with the uniform assessment tool that included all 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). The findings include: During the entrance conference on April 28, 2025, at 10:39 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. R2's diagnoses included cerebral aneurysm (bulge in weak area of a blood vessel in or around brain) /subarachnoid hemorrhage (brain bleed), seizures, paraplegia (type of paralysis that affects the lower half of the body), depression, edema, heartburn, and constipation. R2's Individual Service/Care Plan dated April 10, 2025, included: - supervise with eating (do not leave unattended) provide physical assistance as needed, puree all foods - dressing assist, fully dependent - full assistance with wheelchair, tilt (wheelchair) about 15 degrees to prevent falls. - complete supervisor and administration of all medications - total assistance/care with bowel and bladder	01620		

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01620	Continued From page 21 incontinence. R2's record did not include a service plan. On April 29, 2025, at 11:49 a.m., the surveyor observed unlicensed personnel (ULP)-B take R2 to R2's room and check R2's brief. R2 was seated in a tilt-n-space chair (wheelchair that allowed the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure). ULP-B stated, "you (R2) have been sitting straight up for a while, while you are sitting here I am going to set you back a little here, how does that feel?" R2's comprehensive nursing assessments dated January 24, 2025, and April 23, 2025, respectively lacked the following required content: - spiritual and cultural preferences - advanced health care directives - risk of falls and history of falls - emergency evacuation - elopement risk - smoking status - alcohol and drug use. On April 29, 2025, at 1:06 p.m., R2's assessments were reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she could not locate spiritual and cultural preferences, advance health care directives and end of life preferences (LALD/CNS-A stated topics were on profile sheet but not reviewed every 90 days), risk of falls and history of falls, emergency evacuation, elopement risk, smoking, alcohol and drug use on the current assessment template used. LALD/CNS-A stated the same assessment template was used for all residents. LALD/CNS-A	01620		

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01620	Continued From page 22 stated the licensee was in the process of changing to an online system instead of the current system (paper) used at the facility. The licensee's Assessments, Reviews & Monitoring policy dated July 27, 2022, noted the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 23 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were authenticated to confirm agreement of the services to be provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01640		

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01640	Continued From page 24 The findings include: R2's diagnoses included cerebral aneurysm (bulge in weak area of a blood vessel in or around brain) /subarachnoid hemorrhage (brain bleed), seizures, depression, edema, heartburn, constipation, and hypothyroidism. R2's Individual Service/Care Plan dated April 10, 2025, indicated R2 received services which included medication administration, bathing, hygiene, dressing, telephone use, food preparation, eating, mobility, continence care, housekeeping, laundry, and orientation. R2's record did not include a service plan. On April 28, 2025, at 2:01 p.m., the surveyor observed unlicensed personnel (ULP)-B transfer R2 from a tilt-n-space wheelchair (allows the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure) into bed with aid of a Hoyer (mechanical lift). On April 29, 2025, at 7:07 a.m., the surveyor requested R2's signed service plan via email communication. On April 30, 2025, at 11:39 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was unable to locate R2's service plan. LALD/CNS-A stated R2's service plan could have been misplaced. The surveyor requested R2's service plan be sent to her via email communication, when located. The surveyor did not receive R2's authenticated service plan.	01640		

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01640	Continued From page 25 The licensee's Service Plan policy dated September 27, 2022, noted the Service plan means the written plan between a resident or resident's designated representative and the assisted living site about the services that would be provided to the resident. In addition, the service plan and any revision would include a signature or other authentication by the site, and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse	01650		

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01650	Continued From page 26 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 interview and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1's diagnosis included chronic obstructive pulmonary disease (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation), oxygen dependence, tachycardia (fast heart beat), and hypertension (HTN-high blood pressure). R1's service plan dated May 28, 2020, indicated R1 received the following services: meals, ADL (activities of daily living) assistance, and home management (housekeeping, laundry). R1's service plan noted:	01650		

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01650	Continued From page 27 - see medication, treatment plan and care plan. Registered nurse (RN) would conduct assessments periodically to the level of care appropriate: within five days of admission, reassessment within 14 days of admission, every 90 days thereafter as needed - supervised care: ULPs are under the supervision of a licensed nurse. ULP would be supervised by a RN within 30 days of hire and periodically thereafter. R1's service plan lacked to include the method for resident assessment, and method of monitoring of staff providing services. On April 29, 2025, at 1:06 p.m. R1's service plan was reviewed with licensed assisted living director/clinical nurse supervisor (CNS)-A. CNS-A confirmed R1's service plan did not include the above required information. In addition, LALD/CNS-A stated all of the service plans used were the same and all would be missing the required information. The licensee's Service Plan policy dated September 27, 2022, noted a service plan would include: - a schedule and method for the next planned assessment or monitoring - a schedule and method for the next planned monitoring of staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 28 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of two residents (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included seizures, depression, pain, asthma, bipolar mood disorder (extreme mood swings, extreme excitement episodes or extreme depressive feelings), schizophrenia	01760		

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01760	Continued From page 29 (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior), deep vein thrombosis (blood clot) and frequent headaches. R3's Client (resident) Individual Service/Care Plan dated July 2, 2024, included: medication administration: -agency (licensee) to administrator all medication. R3's April 1, 2025, through April 30, 2025, medication administration record (MAR) included: -hydroco/apap 5/325 milligram (mg) (moderate to severe pain) every six hours: 8:00 a.m., 2:00 p.m., 8:00 p.m. R3's prescriber orders dated February 26, 2025, included hydroco/apap 5/325 mg every six hours. On April 29, 2025, at 12:13 p.m., the surveyor observed unlicensed personnel (ULP)-B administer medication to R3. On April 30, 2025, at 11:29 a.m., the surveyor reviewed R3's MAR and prescriber order with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she (LALD/CNS-A) should have sought clarification for R3's pain medication order. LALD/CNS-A stated "he" (medical provider) wanted R3 to have the pain medication day time hours, and not to wake R3. LALD/CNS-A stated she knew R3 was getting the medication correctly (as medical provider intended). On April 30, 2025, at 11:34 a.m., the surveyor and LALD/CNS-A reviewed R3's hydroco/apap 5/325 mg medication card located in the double locked narcotic box. The pharmacy label for R3's hydroco/apap 5/325 mg noted, take one tablet by	01760		

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01760	Continued From page 30 mouth every six hours for pain. LALD/CNS-A confirmed R3 did not receive hydroco/apap 5/325 mg as prescribed (due to twelve hours without a scheduled dose from 8:00 p.m. to 8:00 a.m.) The licensee's Medication & Treatment Orders-Implementing policy dated September 27, 2022, noted upon receipt of a medication and/or treatment order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours unless clarification is needed. The licensee's Medication Management-Administration & Setup policy dated September 27, 2022, noted a licensed nurse would set up medication in dosage boxes for the resident usually on a weekly basis, and would make or direct changes between set ups when necessary. ULP would verify medication s were set up correctly in the dosage box before administration to the resident by use of the medication profile. If any question of medication accuracy in the dosage box arose, the unlicensed staff would contact the licensed nurse and receive direct instructions on handling any necessary changes a that time, while in direct contact with the nurse. ULP would also document any reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resdient's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01760		

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01770	Continued From page 31	01770		
01770 SS=F	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 two of two residents (R2, 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 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: During the entrance conference on April 28, 2025, at 10:52 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all residents received medication set up by the licensee. R2 R2's diagnoses included cerebral aneurysm (bulge in weak area of a blood vessel in or around brain) /subarachnoid hemorrhage (brain bleed), seizures, depression, edema, heartburn,	01770		

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01770	Continued From page 32 constipation, and hypothyroidism. R2's Client Individual Service/Care Plan dated April 10, 2025, included: medications: - requires complete supervision and administration of all medication. R2's April 1, 2025, through April 30, 2025, medication administration record (MAR) included: - acetaminophen 500 milligrams (mg) (mild pain) three times daily - calcium antacid chew 500 mg (stomach acid) chew thoroughly three times daily - sertraline 25 mg (antidepressant) daily - vitamin D3 50 micrograms (mcg) (supplement) daily - lamotrigine 200 mg (seizures) twice daily - levetiracetam 100 mg (seizures) twice daily - sodium chloride 1 gram (supplement) twice daily - levothyroxine 112 mcg (hypothyroidism) daily - lisinopril 5 mg (heart) daily - M-Natal plus (vitamin/supplement) one daily - oxybutynin 5 mg (overactive bladder) daily - potassium chloride 20 milliequivalents(mEq) (supplement) daily - aspirin 81 mg (heart health/pain) daily - docusate sodium 100 mg (constipation) twice daily. R2's annual prescriber orders dated February 5, 2025, included the above orders. The back page of page one of R2's April 2025, MAR, included: - April 17, 2025, "leg exercises at nap were not done due to pain" - April 1, 2025: Med (medication) Set up per MAR x 7 days, PRN (as needed or as desired) reviewed and made available, medication reordered PRN	01770		

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01770	Continued From page 33 - April 10, 2025: Med Set up per MAR x 7 days, PRN reviewed and made available, medication reordered PRN - April 15, 2025: Med Set up per MAR x 7 days, PRN reviewed and made available, medication reordered PRN - April 25, 2025: Med Set up per MAR x 7 days, PRN reviewed and made available, medication reordered PRN - April 28, 2025: Med Set up per MAR x 7 days, PRN reviewed and made available, medication reordered PRN - all of the above entries were initialed by LALD/CNS-A. R3 R3's diagnoses included seizures, depression, pain, asthma, bipolar mood disorder, schizophrenia, deep vein thrombosis (blood clot) and frequent headaches. R3's Client Individual Service/Care Plan date April 10, 2025, included: medications: - requires complete supervision and administration of all. R3's April 1, 2025, through April 30, 2025, MAR included: - trazodone 150 mg (insomnia) at bedtime - venlafaxine 150 mg (depression daily - acetaminophen 325 mg two tablets three times daily - baclofen 10 mg daily (muscle relaxation/spasms) three times daily - ibuprofen 600 mg (inflammation) three times daily - hydroco/apap 5/325 mg (moderate to serve pain) every six hours - gabapentin 600 mg (nerve pain) at bedtime - mirtazapine 15 mg (depression) at bedtime	01770		

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01770	Continued From page 34 - Xarelto 20 mg (blood clot) daily - gabapentin 300 mg twice daily - hydroxyzine 25 mg (anxiety) at bedtime - senna plus docusate 86 mg (constipation) twice daily - topiramate 50 mg (migraine) twice daily - vitamin D3 25 mcg twice daily - divalproex 250 mg (seizures) daily - divalproex 500 mg three tablets daily - furosemide 20 mg (edema) daily - loratadine 10 mg (allergies) daily. R3's prescriber orders dated February 18, 2025, and February 26, 2025, included the above orders. The back page of page one of R3's April 2025, MAR, included: - entries on wound care dated April 1, 2, 4, 6, 7, 8, 9, 10, 22 and 26, 2025 - April 1, 2025: Med Set up per MAR x 7 days, PRN reviewed and made available, medication reordered PRN - April 10, 2025: Med Set up per MAR x 7 days, PRN reviewed and made available, medication reordered PRN - April 15, 2025: Med Set up per MAR x 7 days, PRN reviewed and made available, medication reordered PRN - April 25, 2025: Med Set up per MAR x 7 days, PRN reviewed and made available, medication reordered PRN - April 28, 2025: Med Set up per MAR x 7 days, PRN reviewed and made available, medication reordered PRN - all of the above entries were initialed by LALD/CNS-A. On April 29, 2025, at 7:04 a.m., the surveyor observed unlicensed personnel (ULP)-B remove	01770		

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01770	Continued From page 35 medications from preset seven-day dosage boxes and place the medication into medication cups with lids. On April 29, 2025, at 12:13 p.m., the surveyor observed ULP-B go to the locked medication storage area in the kitchen and get two medication cups labeled with resident initials. ULP-B took one of the medication cups to R2 and placed the medication into R2's mouth and asked R2 to chew the medication. ULP-B took the remaining lidded medication cup to R3 and stated I (ULP-B) have your noon medication for you (R3). ULP-B administered R3's medication out of the preset medication cup. On April 29, 2025, at 1:32 p.m., the surveyor requested medication set up documentation for residents. LALD/CNS-A stated documentation of medication set up was completed on the back of the resident's MARs. R2 and R3's April 2025, MARs lacked description or other identification of each medication set up by LALD/CNS, however, there was a binder that identified each medication available to unlicensed personnel (ULPs). On April 29, 2025, at 2:17 p.m., R2's and R3's medication set up documentation was reviewed with LALD/CNS-A. LALD/CNS-A stated the medication dosage boxes were set up with the correct medication for each of the licensee's residents. LALD/CNS-A confirmed medication set up documentation did not include the name of each medication, quantity of dose, times to be administered, and route of administration. LALD/CNS-A stated she "looked at" (reviewed) each resident MAR when she (LALD/CNS-A) completed medication set up. LALD/CNS-A	01770		

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01770	Continued From page 36 stated she "thought" by noting on the back of each resident's MAR, and the review of each medication as it was set up, was sufficient. The licensee's Medication Management-Dosage Box Setup policy dated September 27, 2022, noted a licensed nurse would assure the medication were transcribed onto the MAR. This profile included: -dates of medication set up - medication name - quantity of dose - times to be administered - route of administration - name of the person completing the medication setup - visual description of medication - drug classification and special precautions The license nurse transcribed the medication order on the MAR. For medications included in the dosage box, the day and time of administration would be noted on the MAR Medication that could not be set up in the dosage box (topical or liquid) would be recorded on the MAR to include any special instructions and: - medication name - quantity of dose -times to be administered - route of administration - visual description of medication - drug classification and special precautions When the licensed nurse had completed setting up the medications into the dosage box, the set-up was documented on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		

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01880	Continued From page 37	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 28, 2025, at 11:28 a.m., the surveyor and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A toured the facility to include the medication refrigerator. LALD/CNS-A stated the current temperature of the refrigerator was 40 degrees Fahrenheit (F). LALD/CNS-A stated the temperature should be less than 41 degrees F. LALD/CNS-A observed and confirmed the following: - 85 formoterol nebulizer (small machine that creates a mist out of liquid medication, allowing	01880		

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01880	Continued From page 38 for quicker and easier absorption of medication into the lungs) 20 milligram (mg)/2 milliliter (ml) packets (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation) for R1. Directly after the above observation, the April 1, 2025, through April 27, 2025, daily refrigerator log was reviewed with LALD/CNS-A. The daily refrigerator log indicated: - 26 of 27 opportunities the temperature had been recorded - 3 of 27 opportunities the temperature was recorded under 36 degrees F - the temperature readings ranged from 33 to 35 degrees F. The instructions noted: - log must be maintained for each refrigerator in this facility - night staff will record the refrigerator temperature each night - refrigerator temperature should be maintained at 41 F or less. If a corrective action was needed, circle the date and explain action taken in the comment section for example, adjusted thermostat and notified supervisor) - return refrigerator temperature log to supervisor at the end of the month. On April 28, 2025, at 11:35 a.m., LALD/CNS-A stated she did not want to make an excuse but R1's formoterol had been discontinued. LALD/CNS-A confirmed no action had been taken when the temperature was less than 36-degree F as the log form was incorrect. On April 30, 2025, at 8:07 a.m., LALD/CNS-A stated she had reviewed March 2025, medication refrigerator log and found all readings were less than 41, however some of the readings were 35	01880		

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01880	Continued From page 39 degrees. The manufacturer's instructions for formoterol inhalation solution dated April 22, 2025, noted store in a refrigerator at 36 F to 46 F. The licensee's Medication Storage policy dated September 27, 2022, noted medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 ensure medications were maintained bearing legible information including the opened-on date for time sensitive medication for two of two residents (R1, 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	01890		

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01890	Continued From page 40 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 28, 2025, at 11:40 a.m., the surveyor reviewed the contents of the locked medication cabinet with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A observed and confirmed the following: - opened tiotropium bromide (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation) 2.5 micrograms (mcg) for R3, lacked an open and expiration date. - opened Spiriva (tiotropium bromide) 2.5 mcg for R1, lacked an open and expiration date. Directly after the above observation the surveyor reviewed the manufacturer's instructions with LALD/CNS-A. LALD/CNS-A stated she did not know inhalers had an expiration date. LALD/CNS-A stated the medication (inhalers) were used prior to the manufacturer's expiration date. LALD/CNS-A stated she knew insulin had an expiration date and added the licensee did not have any insulin in use at the current time. The manufacturer's instructions for Spiriva dated September 2015, noted throw away the Spiriva inhaler three months after insertion of cartridge into inhaler, even if all the medicine has not been used, or when the inhaler is locked, whichever comes first. The licensee's Medication Storage policy dated	01890		

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01890	Continued From page 41 September 27, 2022, noted medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 two residents (R2)	01950		

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01950	Continued From page 42 receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included cerebral aneurysm (bulge in weak area of a blood vessel in or around brain) /subarachnoid hemorrhage (brain bleed), seizures, paraplegia (type of paralysis that affects the lower half of the body), depression, and edema. R2's record did not include a service plan. R2's treatment plan dated April 10, 2025, included: - TED stocking (compression stocking) on in a.m., (morning), off at bedtime. Use Ace wrap (compression wrap) if TED stockings is not available. R2's Individual Service/Care Plan dated April 10, 2025, included: -TED stocking: on in a.m., off at bedtime. Hand wash and hang to dry. Use Ace wrap of (sic) no Ted Stocking. R2's prescriber order dated February 5, 2025, included Ted stockings on in a.m., off at hour of sleep (HS).	01950		

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01950	Continued From page 43 R2's record did not include contain specific instructions for TEDs to include what/when to report concerns to nursing. On April 28, 2025, at 2:01 p.m., the surveyor observed unlicensed personnel (ULP)-B transfer R2 from a tilt-n-space wheelchair (allows the chair to tilt up to 30-60 degrees, depending on the model, while maintaining hip and knee angles at 90 degrees, designed to help distribute pressure. into bed with aid of a Hoyer (mechanical lift). R2 wore TED stockings. On April 30, 2025, at 8:04 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A reviewed R2's record with the surveyor. LALD/CNS-A stated she was not able to locate when and what to report to nursing regarding R2's TEDs in R2's record. The licensee's Treatment & Therapy Management Plan policy dated September 27, 2022, noted each resident's record must contain: -documentation of specific resident instructions relating to the treatments or therapy administration -procedures for notifying a RN or appropriate licensed health professional when a problem arose with treatments or therapy services -any resident-specific requirements relating to documentation of treatment and therapy received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 44 (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 storage of oxygen for one of one resident (R1) with oxygen tanks. 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: On April 28, 2025, at 10:57 a.m., during the entrance conference licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated one resident used oxygen at the facility (R1). On April 28, 2025, at 11:44 a.m., during a tour of the facility the surveyor and LALD/CNS-A observed: - four tall oxygen tanks in R1's closet unsecured - one small oxygen tank in R1's closet unsecured - 12 tall oxygen tanks secured in R1's closet.	02310		

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02310	Continued From page 45 Directly after the above observation, LALD/CNS-A stated she was not sure why R1 had overflow oxygen tanks. LALD/CNS-A stated all of R1's oxygen tanks were to be secured. The licensee's Oxygen policy dated September 27, 2022, noted, oxygen cylinders and vessels would be kept in a well-ventilated area (not in closets, behind curtains, or other contained space.). The small amount of oxygen gas that is continually vented from these units can accumulate in a confined space and become a fire hazard. Oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	02320		

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02320	Continued From page 46 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered in accordance with accepted standards for one of one unlicensed personnel (ULP)-B who set medications up ahead of time for later administration for two of two residents (R2, R3). This had potential to affect all five residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on April 28, 2025, at 10:52 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated all residents received medication set up by the licensee. ULP-B was hired on March 19, 2024, to provide direct care to the licensee's residents and act as the program manager. ULP-B 's employee record included oral medication competency completed on March 22, 2024: - check the medication administration record (MAR) for the appropriate order - staff member is able to locate and discuss allergies to, side effects and contraindications of	02320		

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02320	Continued From page 47 all medications - assemble supplies: medication, cup of water, applesauce or pudding, if ordered - explain the procedure to the resident - follow the facility/agency protocol for administering medication, i.e. medication may be in medication cart, cabinets, or in pre-filled dosage boxes - before, during, and after medication administration, check the six rights of medication administration by speaking and following out loud: right resident, right medication, right date, right time, right route, right dose - if medications are ordered to be crushed: crush completely and evenly, per protocol, ensure crushing the medication is not contraindicated (e.g. times-released tablets, enteric-coated tablets, etc) - check the expiration date on the medication constrainer and the handwritten date indicating the open date of the medication, if applicable - wash hands or use hand sanitizer, as appropriate - encourage resident to take medication with full glass of water (unless directed otherwise) - check resident's mouth for pocketing, if indicated - document the administration on the MAR. On April 28, 2025, at 11:36 a.m., the surveyor observed in the medication room off the kitchen, a table marked with masking tape that noted resident initials. Next to the masking tape with resident's initials were clear plastic condiment like containers with lids that contained resident medications. The plastic lids were labeled in black permanent marker the following information: resident initials, date and time of the medications were to be administered: - under tape marked (R2).: two small cups with	02320		

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02320	Continued From page 48 lids labeled: 4/28, 12:00 p.m., and 4/28, 2:00 p.m. - under tape marked (R4): one small cup with lid labeled: 4/28, 2:00 p.m. - under tape marked (R3) : two small cups with lids labeled: 4/28 12:00 p.m., and 4/28, 2:00 p.m. - under tape marked (unidentified resident): no cups. On April 28, 2025, at 1:49 p.m., ULP-B stated she set up all "our" (medications administered by ULP-B) in the morning and she "goes from there". On April 29, 2025, at 7:04 a.m., the surveyor observed ULP-B remove medications from preset seven-day dosage boxes and place the medications into clear plastic condiment like containers with lids. On April 29, 2025, at 9:21 a.m., LALD/CNS-A stated she trained ULPs to removed medications from the preset seven day dosage boxes she (LALD/CNS-A) had prepared, and to put the resident's medications into marked (labeled) container that were to be given during the ULPs shift. R2 R2's diagnoses included cerebral aneurysm (bulge in weak area of a blood vessel in or around brain) /subarachnoid hemorrhage (brain bleed), seizures, depression, edema, heartburn, constipation, and hypothyroidism, R2's Individual Service/Care Plan dated date April 10, 2025, included: medications: - requires complete supervision and administration of all medication. R2's April 1, 2025, through April 30, 2025, MAR	02320		

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02320	Continued From page 49 included: - acetaminophen 500 milligrams (mg) (mild pain) three times daily - calcium antacid chew 500 mg (stomach acid) chew thoroughly three times daily - sertraline 25 mg (antidepressant) daily - vitamin D3 50 micrograms (mcg) (supplement) daily - looting 200 mg (seizures) twice daily - levetiracetam 100 mg (seizures) twice daily -sodium chloride 1 gram (supplement) twice daily -levothyroxine 112 mcg (hypothyroidism) - lisinopril 5 mg (heart) daily - M-Natal plus (vitamin/supplement) one daily - oxybutynin 5 mg (overactive bladder) daily - potassium chloride 20 milliequivalents(mEq) (supplement) - aspirin 81 mg (heart/pain) daily - docusate sodium 100 mg (constipation) two daily. R2's annual prescriber orders dated February 5, 2025, included the above orders. R3 R3's diagnoses included seizures, depression, pain, asthma, bipolar mood disorder, schizophrenia, deep vein thrombosis (blood clot) and frequent headaches. R3's Individual Service/Care Plan dated July 2, 2024, included: medication administration: - agency (licensee) to administrator all medication. R3's April 1, 2025, through April 30, 2025, MAR included: - trazodone 150 mg (insomnia) at bedtime - venlafaxine 150 mg (depression daily - acetaminophen 325 mg two tablets three times	02320		

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02320	Continued From page 50 daily - baclofen 10 mg daily (muscle relaxation/spasms) three times daily - ibuprofen 600 mg (inflammation) three times daily - hydroco/apap 5/325 mg (moderate to severe pain) every six hours - gabapentin 600 mg (nerve pain) at bedtime - mirtazapine 15 mg (depression) at bedtime - Xarelto 20 mg (blood clot) daily - gabapentin 300 mg twice daily - hydroxyzine 25 mg (anxiety) at bedtime - senna plus docusate 86 mg (constipation) twice daily - topiramate 50 mg (migraine) twice daily - vitamin D3 25 mcg twice daily - divalproex 250 mg (seizures) daily - divalproex 500 mg, three tablets daily - furosemide 20 mg (edema) daily - loratadine 10 mg (allergies) daily. R3's prescriber orders dated February 18, 2025, and February 26, 2025, included the above orders. On April 29, 2025, at 12:13 p.m., the surveyor observed ULP-B go to the locked medication storage area in the kitchen and get two clear plastic condiment like containers with lids that were labeled with residents initials and put the two medication containers into a small basket. The surveyor did not observe ULP-B check resident MARs. ULP-B took one of the containers of medication to R2 and placed the medication into R2's mouth and asked R2 to chew the medication. ULP-B took the remaining lidded medication cup to R3 and stated I (ULP-B) have your noon medication for you (R3). ULP-B administered R3's medication out of the preset medication cup.	02320		

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02320	Continued From page 51 On April 29, 2025, at 12:15 p.m., ULP-B documented R2 and R3's medication as administered in the appropriate MAR. On April 29, 2025, at 12:17 p.m., ULP-B stated she did not check R2 or R3's MAR prior to medication administration because "I preset them (medication) this morning and checked the MARs at that time." On April 29, 2025, at 2:38 p.m., the surveyor reviewed ULP-B's medication pre-set up process and medication administration observation with LALD/CNS-A. LALD/CNS-A stated most of the resident medications came from the pharmacy in bubble packs (a transparent molded piece of plastic often sealed to a sheet of cardboard, used to package tablets) and LALD/CNS-A took those medications and set up them in a medication dosage box every Tuesday. ULP's were trained to take the medications from the medication dosage boxes and set them up in individual medication containers to administer at a later time. LALD/RN-A stated since she started that practice, it had reduced medication errors. LALD/CNS-A stated ULPs were trained to pre-set up medications. LALD/CNS-A showed the surveyor the licensee's undated Medication Set Up Procedure for Shift, which included: - verify your client (resident) group on the curdle if working with another staff - you will need the following: medication cups/lids, MARs, and medication bins - grab medication cups/lids basket - take each client's book, one a a time and open the MAR page - take the client's bin that you will be working on - wash or sanitize your hands - gently take out the pill container to avoid spilling	02320		

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02320	Continued From page 52 medications - double check the name on the sides of the pill box against the client's MAR. - take out the individual day (ex. Monday) and shift (ex. PM shift) container that you will be setting up - securely hold covers to the pill container - check name at the bottom (matching client's name) - open pill container for the time you are going to set up, pour medications into medication cup while holding other pill lids closed - count the medication in the pill up - write the following on the medication lid: - client initials - number of pills - date of your shift - time of administration - check MAR for other treatments for example, inhalers, creams, powders, eye drops, nebs, insulin, blood sugars, and so forth - also write the treatments on the medication lid, if no room, use the medication lid rim - repeat the steps and set up all mediations and treatments for the clients in your care during your shift and place in designated area. In addition, at this time the licensee's undated Six Rights of Medication Administration was reviewed with LALD/CNS-A, which included: - check the name on the client's medication label - make sure that you are pouring out medication for the right client staff MUST do one client at a time - label medication cup with the right client's initial and bring it to that client IMMEDIATELY. LALD/CNS-A stated she felt the process in-place reduced medication errors. In addition, LALD/CNS-A stated she was not aware that ULPs could not preset up resident medications.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32149	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTONE HEALTH CARE INC	319 7TH STREET PROCTOR, MN 55810

(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
02320	Continued From page 53 On April 29, 2025, at 11:41 a.m., the surveyor reviewed the licensee's Medication Set Up Procedure for Shift, with LALD/CNS-A. LALD/CNS-A stated ULP-B did not follow the procedure as written. On April 29, 2025, at 11:44 a.m., LALD/CNS-A stated she did not understand the process used was not correct, acceptable. The licensee's Medication Management-Administration & Setup policy dated September 27, 2022, noted a licensed nurse would correctly and accurately document any medication setup provided. Documentation of medication assistance or medication administration would be completed immediately after that task had been performed. For active assistance with medications from the dosage box system, the ULP would use the MAR for documenting medication given from a dosage box and would refer to the medication profile listing the medication name, dosage, dale, and time administered. It would also include the purpose of the medication and any special instructions if applicable No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02320		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32149	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTONE HEALTH CARE INC	319 7TH STREET PROCTOR, MN 55810

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03090	Continued From page 54 record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity potentially, affecting all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 28, 2025, at 10:37 a.m., upon entrance of the facility, the surveyor observed signage posted at the main entrance that indicated, "WARNING This Property is Under 24 Hour Video Surveillance, Audio May be Recorded". On April 28, 2025, at approximately 12:15 p.m., the facility's electronic sign wording was reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A stated she "thought" the posted sign contained the required wording and stated a surveyor had in the past stated the sign was correct. The surveyor reviewed the sign requirement with LALD/CNS-A.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32149	A. BUILDING: _____ B. WING _____	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTONE HEALTH CARE INC	319 7TH STREET PROCTOR, MN 55810

(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
03090	Continued From page 55 On April 28, 2025, at 12:45 p.m., LALD/CNS-A stated she had posted the correct and required electronic wording as required this day. On April 29, 2025, at approximately 1:30 p.m., LALD/CNS-A stated she was not sure but thought there might be 20 or so cameras at the facility, counting interior and exteriors cameras. The licensee's Electronic Monitoring policy dated September 27, 2022, noted signs were installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Lifestone Health Care
319 7th Street
Proctor, MN 55810
St. Louis County
Parcel:

Phone: 218-481-7306

License Info

License:
Chiamaka Enemuoh
Risk:
License:
Expires on:
CFPM: None
CFPM #: ; Exp:

Inspection Info

Report Number: F1006251003
Inspection Type: Full - Single
Date: 4/29/2025 Time: 10:15:00 AM
Duration: 60 minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: CHIAMAKA TOOK A FOOD MANAGERS COURSE AFTER THE PREVIOUS INSPECTION, BUT DIDN'T APPLY FOR THE STATE CERTIFICATE. DISCUSSED STEPS ON HOW TO OBTAIN THE STATE CERTIFICATE AND INFO LEFT WITH OWNER.
Comply By: 6/25/2025 Originally Issued On: 4/29/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: THE PRODUCE DRAWER IN THE UPRIGHT REFRIGERATOR WAS BADLY CRACKED AND HAD BEEN TAPED. THIS IS NO LONGER SMOOTH AND EASY TO CLEAN. DISCUSSED WITH OWNER THAT DRAWER WOULD BE REMOVED AND THEY WILL LOOK FOR A REPLACEMENT.
Comply By: 5/1/2025 Originally Issued On: 4/29/2025

Food & Beverage General Comment

Kitchen is clean and orderly. Discussed day to day operations with owner and staff. All meals are prepared immediately before service and leftovers are not kept.

Temperatures taken:
Refrigerator 1: 37F pickles, 38F grape jelly, freezer all foods were frozen
Refrigerator 2: 38F milk, freezer all foods were frozen

Sanitizers:
Quaternary ammonia sanitizer spray mixed on site was 400 ppm.
High-temp dish machine- reached at least 160F, test strip turned black.

Discussed the importance of proper hand washing and glove use with all ready to eat foods.

Discussed the employee illness policy and the exclusion of employees sick with symptoms of vomiting and/or diarrhea until they have been symptom free for at least 24 hours. Employee illness must be recorded.

Also, contact the department of health if any employees are diagnosed with hepatitis A., shiga toxin-producing E. coli,

salmonella, shigella, or norovirus or if there are any suspected foodborne illness complaints.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Duluth District Office inspection report number F1006251003 from 4/29/2025

Callie Harrison

Chiamaka Enemuoh

Callie Harrison,
Public Health Sanitarian 3
218-302-6173
callie.harrison@state.mn.us

Minnesota (MDH) Version
EH Manager; RPT: F1006251003

Food Establishment Inspection Report

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

No. of Risk Factor/Intervention/Violations	1	Date: 4/29/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:15 AM
Score (optional)		Dur: 60 min

Establishment:	Address:	City/State:	Zip:	Phone:
Lifestone Health Care	319 7th Street	Proctor, MN	55810	218-481-7306
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
	Chiamaka Enemuoh	Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	OUT	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	N/O	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions 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" or OUT 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	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
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 and used		
46		Gloves used properly		
		Utensils, 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 and plan review		

Person in Charge (signature)

Inspector (signature) [redacted]

Follow-up: Follow-up Date: