DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 24, 2022

Administrator
McCarthy Manor INC
2221 North Arlington Avenue
Duluth, MN 55811

RE: Project Number(s) SL30315015

Dear Administrator:

On August 11, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 23, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-592-5119 Fax: 651-215-9697

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Electronically Delivered

July 20, 2022

Administrator
McCarthy Manor Inc
2221 North Arlington Avenue
Duluth, MN 55811

RE: Project Number SL30315015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 23, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jessica Chenze

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30315	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCARTHY MANOR INC	2221 NORTH ARLINGTON AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30315015 On, June 21, 2022, through June 23, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 28 residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on June 21, 2022, issued for SL30315015, tag identification 2310. On June 22, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 21, 2022, at approximately 9:36 a.m., during entrance conference, registered nurse (RN)-A and assistant administrator (AA)-B identified licensed assisted living director (LALD)-E as being the LALD for the licensee. LALD-E obtained an assisted living director license on June 24, 2021. On June 22, 2022, at approximately 8:33 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-E held a current assisted living director license. The BELTSS website did not indicate LALD-E as the	0 110		

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0 110	Continued From page 2 Director of Record for the licensee. On June 22, 2022, at approximately 8:43 a.m., AA-B confirmed LALD-E was not listed as the Director of Record for the licensee. AA-B stated she was not aware of the requirement for the Director of Record and would inform LALD-E of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by:	0 460		

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0 460	Continued From page 3 Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all 28 residents currently residing in 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: The licensee held an assisted living facility license and was licensed for a bed capacity of 32 residents. The current census at the facility was 28 residents. On June 21, 2022, at approximately 9:43 a.m., during the entrance conference, assistant administrator (AA)-B and registered nurse (RN)-A stated the facility did not have a system in place for residents to summon staff for assistance. AA-B stated the licensee provided safety checks for all residents at medication and mealtimes, and at 10:00 p.m. AA-B stated the licensee's residents were independent with their mobility and would be able to go let staff know if they needed anything. AA-B further stated if a resident fell in their room and could not get up, the resident would have to yell out to summons staff or would be found during one of the safety checks. No other information provided.	0 460		

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0 460	Continued From page 4 TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on June 21, 2022, at	0 550		

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0 550	Continued From page 5 approximately 10:28 a.m., the surveyor observed, with assistant administrator (AA)-B, the main entrance had the licenses' grievance procedure posted; however, the grievance procedure posting lacked the required content to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. On June 9, 2022, at approximately 10:38 a.m., AA-B confirmed the licensee's grievance procedure posted did not include the required content as noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for unaccounted controlled medication and complete a thorough investigation for one of	0 620		

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0 620	Continued From page 6 one resident (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included anxiety, bipolar one (a form of mental illness), hypothyroidism (low thyroid level), chronic knee pain R4's Service Plan (Waiver)-Addendum dated December 23, 2021, indicated R4 received medication management services. On June 7, 2022, R4 was prescribed Codeine-Guaifen (a cough suppressant and expectorant which contains a narcotic)10 milliliter (ml) every six hours as needed for a cough. On June 21, 2022, at approximately 10:50 a.m. the surveyor observed the locked narcotic box located in the medication cart with registered nurse (RN)-A. R4 had a bottle of Codeine-Guaifen with approximately 20 ml left in the bottle. R4's Narcotic Count Sheet indicated there was 40 ml of medication that had been unaccounted for. On June 21, 2022, at approximately 10:55 a.m., RN-A stated she was told R4's Codeine-Guaifen count was off by 40 ml about a week prior. RN-A stated she reconciled the medication by making a	0 620		

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0 620	Continued From page 7 dose correction on R4's Narcotic Count Sheet to reflect the amount of liquid medication that was in the bottle at that time. RN-A verified R4's Narcotic Count Sheet indicated there should have been 150 ml left in R4's Codeine-Guaifen at the time the discrepancy was discovered but there was only 110 ml, which indicated 40 ml of R4's medication was missing and unaccounted for. RN-A confirmed she did not complete an investigation to determine if there was any theft or drug diversion, nor called and reported the missing narcotic to MAARC (Minnesota Adult Abuse Reporting Center). RN-A confirmed the stored narcotics were not being regularly counted and she completed audits on the narcotic counts every other week. RN-A confirmed the licensee's Loss or Spillage of Medication Including Controlled Medications was not followed. The licensee's undated Loss or Spillage of Medication, Including Controlled Medications indicated when loss or spillage of any medication occurs, notation must be made in the client's medication record explaining the spillage and the actions taken. If the loss or spillage was a controlled medication, the notation about the loss or spillage must be signed by the person responsible and one witness. The agency was required to take appropriate action under the federal or state regulations for any loss of unaccounted prescription drugs when theft or diversion was suspected. If theft or diversion was suspected, documentation would include the investigations and findings. If theft or diversion of prescription drugs was suspected, it must be reported to local law enforcement and may require a report to the MAARC (Minnesota Adult Abuse Reporting Center). No further information was provided.	0 620		

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0 620	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced	0 650		

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0 650	Continued From page 9 by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-A RN-A had a hire date of May 24, 2021, under the comprehensive home care license, and began providing services under the licensee's Assisted Living license on August 1, 2021. RN-A's employee record lacked the following required content: -documentation of annual performance review that identified areas of improvement needed and training areas. On June 22, 2022, at approximately 11:30 a.m., RN-A stated she had not had an annual job performance review completed. ULP-C ULP-C had a hire date of November 4, 2020,	0 650		

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0 650	Continued From page 10 under the comprehensive home care license, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-C's employee record lacked the following required content: -annual job performance review to include documentation of annual performance review that identified areas of improvement needed and training areas; and -evidence ULP-C completed training, including demonstrated competency for assisting with oxygen therapy. On June 22, 2022, at approximately 2:32 p.m., assistant administrator (AA)-B verified RN-A and ULP-C's employee records lacked job performance reviews. On June 22, 2022, at approximately 3:22 p.m., RN-A verified ULP-C's oxygen skill competency was blank and had not been completed. RN-A stated ULP-C may not have been trained on oxygen management at the time of hire because the licensee did not have any residents on oxygen at that time but currently do. The licensee's undated Personnel Records policy indicated personnel records would be kept up to date and would comply with the assisted living law and other relevant laws. In addition, the policy indicated the personnel records for each person would include performance evaluations which would identify areas of improvement needed and training needs and performance reviewed must be conducted at least annually. The licensee's undated Training and Competency Evaluations of Unlicensed Staff indicated training and competency evaluations of unlicensed	0 650		

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0 650	Continued From page 11 personnel must be conducted by a RN or other instructor in conjunction with the RN. Other Licensed Health Professionals may train and conduct competency evaluations of unlicensed personnel for tasks that can be delegated by the Licensed Health Professional within his/her professional scope of practice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease	0 660		

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0 660	Continued From page 12 Control and Prevention (CDC) and the Minnesota Department of Health (MDH), which included a TB risk assessment which was reviewed annually. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: The licensee's Facility Tuberculosis (TB) Risk Assessment Worksheet was completed last on July 24, 2019, and indicated a low risk level. On June 23, 2022, at approximately 10:48 a.m., registered nurse (RN)-A provided the surveyor with a white binder which contained the licensee's TB Risk assessments dated from 2009-2019. RN-A confirmed the licensee's risk assessment had not been reviewed since July 24, 2019. The licensee's TB Prevention and Control policy dated August 1, 2021, indicated the licenses' TB risk assessment would be reviewed annually and updated as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		

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0 680	Continued From page 13	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 14 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: During entrance conference on June 21, 2022, at approximately 9:36 a.m., the surveyor asked to view the licensee's emergency preparedness plan (EPP). The licensee's Emergency Disaster Plan dated November 2021, lacked the following required content: - process for EP cooperation with state and local EP officials/organizations; - a thoroughly completed risk assessment; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites. - a communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for	0 680		

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0 680	Continued From page 15 communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On June 23, 2022, assistant administrator (AA)-B stated the licensee does not have an actual emergency preparedness binder with all the above required content noted above. AA-B stated licensed assisted living director (LALD)-E had developed some emergency disaster policies, a risk assessment of the area, had arranged a place to evacuate and plans for transportation. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to maintain the facility physical environment	0 800		

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0 800	Continued From page 16 in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 06/23/2022, between 8:00AM and 10:00AM, survey staff toured the facility with Assistant Administrator-B, during the facility tour, survey staff observed Emergency Lighting to be in disrepair, battery power nonfunctioning. Following areas: 1. Kitchen area behind door 2. Basement, at end of hall - south end Assistant Administrator-B verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics:	01470		

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01470	Continued From page 17 (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:	01470		

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01470	Continued From page 18 (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for two of two employees registered nurse (RN)-A and unlicensed personnel (ULP-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RN-A RN-A had a hire date of May 24, 2021, under the comprehensive home care license, and began providing services under the licensee's Assisted Living license on August 1, 2021.	01470		

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01470	Continued From page 19 RN-A's transcript indicted RN-A completed Home Care Orientation and Home Care Bill of Rights on July 2, 2021. RN-A's employee record lacked the following required orientation content: - an overview of the 144G statutes; -policies and procedures related to the provision of assisted living services by the individual staff person; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -assisted living Bill of Rights. ULP-C ULP-C had a hire date of November 4, 2020, under the comprehensive home care license, and began providing services under the licensee's Assisted Living license on August 1, 2021. ULP-C's transcript indicated ULP-C completed Home Care Orientation on November 8, 2020, Assisted Living Bill of Rights-MN on November 17, 2021, and Person-Centered Care Principle on December 29, 2021. ULP-C's employee record lacked the following required orientation content: - an overview of the 144G statutes; -policies and procedures related to the provision of assisted living services by the individual staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01470		

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01470	Continued From page 20 On June 22, 2022, at approximately 1:40 p.m., office manager (OM)-D confirmed RN-A and ULP-C's employee records lacked the above noted required orientation content. OM-D stated she had not assigned the new Educare training Guide to Assisted Living Minnesota to employees and instead had assigned Home Care Orientation and Home Care Bill of Rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be	01530		

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01530	Continued From page 21 available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees registered nurse (RN)-A received the dementia care training in the required time frame with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The finding include: RN-A was hired on May 24, 2021, under the licensee's comprehensive home care license to provide and supervise direct care services to the licensee's residents and continued to under the assisted living license on August 1, 2021. RN-A's employee record indicated RN-A had completed 3.25 hours of dementia care training and did not meet a total of eight (8) hours of the required dementia training within 120 hours of the employee's start date. On June 22, 2022, at approximately 1:40 p.m., office manager (OM)-D confirmed RN-A did not	01530		

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01530	Continued From page 22 meet the required dementia care training hours. The licensee's undated Assisted Living Dementia Training policy indicated supervisors of direct care staff would complete a minimum of eight (8) hours initial training on dementia care topics within 120 working hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01690 SS=D	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and	01690		

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01690	Continued From page 23 designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the security and accountability of controlled substances was maintained for one of one resident (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 21, 2022, at approximately 9:36 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services for residents at the facility and some residents had a controlled substance prescribed (a drug or other substance that may be abused or cause addiction and is tightly controlled by the government). R4's Service Plan (Waiver)-Addendum dated December 23, 2021, indicated R4 received	01690		

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01690	Continued From page 24 assistance with medications. R4's Medication Administration Summary from June 6, through June 21, 2022, indicated R4 received Codeine- Guaifenesin (a cough suppressant and expectorant with a narcotic)10-100 milligrams (mg) 10 mg every six hours as needed for cough. On June 21, 2022, at approximately 10:50 a.m., the surveyor observed the locked narcotic box which was secured in the medication cart. The surveyor reviewed R4's Narcotic Count Sheet (a record where staff document the removal and addition of controlled substances). On line eight, staff documented on June 10, 2022, at 11:09 a.m., 10 ml of Codeine-Guaifenesin was signed out by staff with a remaining amount of 150 ml in R4's bottle of Codeine-Guaifenesin. The next entry, line nine, had a line drawn through it and indicated 110 ml remained in the bottle. The signature space depicted, "dose correction" with RN-A and ULP-C's initials. During an interview on June 21, 2022, at approximately 10:55 a.m., RN-A stated staff working the medication cart did not reconcile residents' stored narcotics or controlled medications and RN-A would attempt to randomly reconcile residents' narcotics and controlled medications every other week. RN-A stated it was brought to her attention that R4's Guaifenesin with Codeine count was off by 40 ml. She said the 40 ml was unaccounted for, and further stated no investigation was completed to determine if theft or drug diversion occurred because there was a camera in the room where staff set up and administered medications, so therefore didn't think anyone would "steal medications with a camera watching". RN-A	01690		

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01690	Continued From page 25 confirmed she did not document the unaccounted controlled medication and just corrected the dose by what was remaining in the bottle at that time. The licensee's undated Loss or Spillage of Medication, Including Controlled Medications indicated when loss or spillage of any medication occurs, notation must be made in the client's medication record explaining the spillage and the actions taken. If the loss or spillage was a controlled medication, the notation about the loss or spillage must be signed by the person responsible and one witness. The agency was required to take appropriate action under the federal or state regulations for any lost or unaccounted prescription drugs when theft or diversion was suspected. If theft or diversion was suspected, documentation would include the investigations and findings. If theft or diversion of prescription drugs was suspected, it must be reported to local law enforcement and may require a report to the MAARC (Minnesota Adult Abuse Reporting Center). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what	01700		

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01700	Continued From page 26 medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a self-medication assessment for one of one resident (R1) administering own insulin. 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).	01700		

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01700	Continued From page 27 The findings include: R1's diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), diabetes, macular degeneration (eye condition that causes vision loss), and hypertension (high blood pressure). R1's Service Plan Addendum dated February 1, 2022, indicated R1 received assistance with medications. R1's prescriber orders dated March 20, 2022, included an order for Basaglar insulin 26 units twice a day. R1's prescriber orders dated March 23, 2022, included an order for Novolog insulin 5 units with meals and to hold if glucose was less than 100. R1's May 2022, and June 2022, Medication Administration Summary indicated R1 received the following insulins: -Novolog 100 units/milliliters (u/ml) insulin 5 units three times daily with meals and to hold if blood glucose is less than 100; and -Basaglar 100 u/ml 26 units twice a day. On June 22, 2022, at approximately 10:42 a.m., (unlicensed personnel) ULP-C was observed monitoring R1 in self-administering of insulin. On June 23, 2022, at approximately 2:47 p.m., RN-A confirmed R1's record lacked a self-administration medication assessment for R1 to be able to administer own insulin. The licensee's undated Initial and On-Going Nursing Assessments of Clients indicated the RN would complete assessment of the client's need for medication management services, including	01700		

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01700	Continued From page 28 medication set up and medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used	01790		

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01790	Continued From page 29 for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01790		

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01790	Continued From page 30	01790		

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During entrance conference on June 21, 2022, at approximately 9:36 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services to all residents at the facility. RN-A confirmed the ULP would prepare and send medications with residents for unplanned times away.

The licensee's lacked a written policy and procedure for unplanned and planned time away to include:
- the type of container or containers to be used for the medications appropriate to the provider's medication system;
- how the containers should be labeled:
- written information about the medications to be provided;
- how the ULP must document in the resident's record that medications have been provided, including documenting who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
- how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or designated representative;
- review by the RN of the completion of this task to verify that this task was completed accurately

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01790	Continued From page 31 by the unlicensed personnel; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. On June 23, 2022, at approximately 2:47 p.m., RN-A and assistant administrator (AA)-B licensed confirmed the licensees did not have a written policy or procedure for residents who required to have their medications sent with them for planned or unplanned time away with the above noted content as required. The surveyor was provided a Competency Evaluation for Medication Administration and/or Delegated Tasks form. RN-A confirmed the competency form was not updated to reflect the licensee's current medication administration system and lacked required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
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 the medication refrigerator maintained an acceptable	01880		

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01880	Continued From page 32 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 June 21, 2022, at approximately 10:45 a.m., the surveyor observed the mediation refrigerator with registered nurse (RN)-A. RN-A confirmed the current medication refrigerator temperature was 36 degrees Fahrenheit (F) and there was ice buildup in and around the freezer. RN-A stated during the week, the nurse monitors and records the medication fridge temperatures and on the weekends the day staff working the medication cart were responsible to check and record fridge temperatures. The surveyor requested medication refrigerator logs for the past three (3) months. On June 21, 2022, at approximately 2:20 p.m., RN-A provided recorded temperature logs for April, May, and June of 2022. The surveyor reviewed the recorded temperature logs which were missing one entry for April, four entries for May and two entries for June. In addition, there were several recorded temperatures below 36 degrees F which is out of the recommended temperature range of 36 degrees F-46 degrees F. RN-A confirmed the missing entries and recorded refrigerator temperatures which were below 36	01880		

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01880	Continued From page 33 degrees F. RN-A stated the concern of the temperatures falling below 36 degrees F would be the medications were at risk for freezing and planned on calling the pharmacy for guidance. The medication refrigerator temperature logs indicated the following: -April 2022, log contained 29 of a possible 30 temperatures recorded and 13 were below 36 degrees F. -May 2022, log contained 27 of a possible 31 temperatures recorded and 15 were below 36 degrees F. -June 2022, log contained 17 of a possible 19 temperatures recorded and 12 were below 36 degrees F. On June 22, 2022, at approximately 8:50 a.m., the contents of the medication refrigerator were observed and recorded with RN-A and contained the following medications: -10 unopened Basaglar 100 units/milliliters (ml) insulin pens (a multiple dose shaped injector device for insulin administration), and four unopened Novolog 100 units/ml insulin pens for R1; - three unopened Lantus SoloStar 100 units/ml insulin pens, and four Lispro 100 units/ml insulin pens for R6; - four unopened Lantus SoloStar 100 units/ml insulin pens for R7; -two bottles of latanoprost 0.05% eye drops (medication to treat high pressure in the eye) for R8; -four bottles of latanoprost 0.05% eye drops for R9; -on bottle of Rocklantan ophthalmic (medication to treat high pressure in the eye) eye drop for R10; and -two Risiperdal (used to treat certain	01880		

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01880	Continued From page 34 mental/mood disorders such as schizophrenia, bipolar disorder, irritability associated with autistic disorder) pens for R11. The manufacturer instructions for Basaglar KwikPen revised July 2021, directed to store unopened insulin pens in the refrigerator at 36 degrees F to 46 degrees F and further directed not to use Basaglar insulin if it had been frozen. The manufacturer instructions for Novolog Flexpen revised September 2021, directed to store unopened insulin cartridges in the refrigerator at 36 degrees F to 46 degrees F and do not freeze or use if it had been frozen. The manufacturer instructions for Lantus SoloStar insulin revised May 2018, directed to store unopened insulin pens in the refrigerator at 36 degrees F to 46 degrees F and not to freeze. The manufacturer instructions for latanoprost ophthalmic solution revised August 2011, directed to store unopened in the refrigerator at 36 degrees F to 46 degrees F. The manufacturer instructions for Rocklatan ophthalmic solution revised June 2020, directed to store unopened or opened in the refrigerator at 36 degrees F to 46 degrees F. The licensee's undated Storage of Medications policy indicated the RN would provide education on proper storage of medications including the need to be refrigerated and according to manufacturer's recommendation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01880		

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01880	Continued From page 35 days	01880		
01890 SS=E	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 the original prescription label with legible information including the expiration date for time sensitive medications for five of seven residents (R1, R6, R10, R12, R13) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 21, 2022, at approximately 10:50 a.m., the surveyor observed the medication cart with registered nurse (RN)-A and confirmed the following:	01890		

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01890	Continued From page 36 R1 R1's opened Basaglar 100 units/milliliters (ml) insulin pens (a multiple dose shaped injector device for insulin administration) lacked the date the insulin had been opened or would expire. R6 R6's opened Lantus SoloStar 100 units/ml and Lispro 100 units/ml insulin pens lacked a date the insulins were opened and would expire. R10 R10's opened Alphagan (latanoprost) ophthalmic suspension lacked a date the eye drop was opened or would expire. R10's Rocklatan eye drop lacked an original prescription label and the date the eye drop was opened and would expire. R12 R12's opened Albuterol and Combivent inhalers lacked the original prescription label and the date the inhalers were opened and would expire. R13 R13's opened Advair Diskus inhaler lacked the original prescription label and the date the inhaler was opened and would expire. On June 21, 2022, at approximately 11:00 a.m., RN-A stated staff have been educated on writing the opened date on eye drops, insulins and inhalers and staff were recently sent a message regarding dating time-sensitive medications. RN-A confirmed medications should have an original prescription label and if a medication was lacking a prescription label to contact pharmacy and request a label. The manufacturer's instructions for Basaglar	01890		

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01890	Continued From page 37 revised dated 2015, indicated insulin pens stored at room temperature must be used within 28 days or discarded. The manufacturer's instructions for Lispro insulin pens revised February 2020, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Lantus insulin pens dated December 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Rocklatan eye drop revised June 2020, indicated after opening, the product may be kept for up to six weeks if stored at room temperature. The manufacturer's instructions for latanoprost ophthalmic solution revised August 2011, to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Combivent inhaler revised August 2012, directed to throw away three months after insertion of cartridge into inhaler, even if all the medicine had not been used. The manufacturer's instructions for Advair Diskus inhaler revised April 2008, directed to date the inhaler was removed from the foiled package and use within one month after opening inhaler. The licensee's undated Storage of Medications policy indicated the RN would provide education on proper storage of medications in according to manufacturer's recommendation. The medication must be kept in its original container bearing the	01890		

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01890	Continued From page 38 original prescription label with legible information stating the prescription number, name of the drug, strength and quantity of drug, expiration date of time-dated drugs, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	01910		

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01910	Continued From page 39 Based on interview and record review, the licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R5) upon discharge, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 was discharged on February 12, 2022. R5's prescriber orders dated February 10, 2022, included three medications to reduce blood pressure, one medication to lower cholesterol levels, three medications to assist with diabetes and one medication to treat a rapid heartbeat. R5's Discharge - Transfer Summary dated February 14, 2022, noted medications were sent with R5's. In addition, the summary noted R5 received assistance with medication management including administration. The summary included a Medication Disposition Summary, which noted disposition of medications to include the medication name, quantity, strength, however; lacked the prescription numbers of the medications sent with R5. On June 22, 2022, at approximately 12:04 p.m., registered nurse (RN)-A confirmed R5's disposition of medications lacked the prescription	01910		

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01910	Continued From page 40 number of the medications sent with R5. RN-A stated she was not aware it was required for all medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01920 SS=D	144G.71 Subd. 23 Loss or spillage (a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations. (b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to follow the procedure for loss and spillage of a controlled substance for one of one resident (R4), who had a controlled substance managed by the facility.	01920		

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01920	Continued From page 41 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included anxiety, bipolar one (a form of mental illness), hypothyroidism (low thyroid level), chronic knee pain R4's Service Plan (Waiver)-Addendum dated December 23, 2021, indicated R4 received medication management services. On June 7, 2022, R4 was prescribed Codeine-Guaifen (a cough suppressant and expectorant which contained a narcotic)10 milliliter (ml) every six hours as needed for a cough. R4's Medication Administration Summary from June 6, through June 21, 2022, indicated R4 received Codeine-Guaifen 10 ml on the following days: June 8-three doses June 9- one dose June 10-two doses June 11-one dose June 12-two doses June 13-one dose June 14-one dose June 15-one dose June 16-one dose June 20-one dose	01920		

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01920	Continued From page 42 June 21-one dose On June 21, 2022, at approximately 10:50 a.m. the surveyor observed the locked narcotic box located in the medication cart with registered nurse (RN)-A. R4 had a bottle of Codeine-Guaifen with approximately 20 ml left in the bottle. R4's Narcotic Count Sheet indicated there was 40 ml of medication that had been unaccounted for. On June 21, 2022 at approximately 10:55 a.m., RN-A stated she was told R4's Codeine-Guaifen count was off by 40 ml about a week prior. RN-A stated she reconciled the medication by making a dose correction on R4's Narcotic Count Sheet to reflect the amount of liquid medication that was in the bottle at that time. RN-A verified R4's Narcotic Count Sheet indicated there should have been 150 ml left in R4's Codeine-Guaifen at the time the discrepancy was discovered but there was only 110 ml, which indicated 40 ml of R4's medication was missing and unaccounted for. RN-A confirmed she did not complete an investigation to determine if there was any theft or drug diversion, nor called and reported the missing narcotic to MAARC (Minnesota Adult Abuse Reporting Center). RN-A confirmed the stored narcotics were not being regularly counted and she completed audits on the narcotic counts every other week. RN-A confirmed the licensee's Loss or Spillage of Medication Including Controlled Medications was not followed. The licensee's undated Loss or Spillage of Medication, Including Controlled Medications indicated when loss or spillage of any medication occurs, notation must be made in the client's medication record explaining the spillage and the	01920		

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01920	Continued From page 43 actions taken. If the loss or spillage was a controlled medication, the notation about the loss or spillage must be signed by the person responsible and one witness. The agency was required to take appropriate action under the federal or state regulations for any loss of unaccounted prescription drugs when theft or diversion was suspected. If theft or diversion was suspected, documentation would include the investigations and findings. If theft or diversion of prescription drugs was suspected, it must be reported to local law enforcement and may require a report to the MAARC (Minnesota Adult Abuse Reporting Center). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or	01960		

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01960	Continued From page 44 therapies were administered as prescribed for one of two residents (R1) reviewed who received 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: R1's diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), diabetes, macular degeneration (eye condition that causes vision loss), and hypertension (high blood pressure). R1's service plan addendum dated February 1, 2022, indicated R1 received blood glucose monitoring three times a day. R1's prescriber orders dated March 9, 2021, included an order for blood glucose monitoring to be completed three times a day (6:30 a.m., 4:00 p.m., and 6:30 p.m.). R1's May 2022, and June 2022, service recap summary indicated R1 received blood glucose monitoring four (4) times a day (6:30 a.m., 11:00 a.m., 4:00 p.m., and 7:00 p.m.). On June 22, 2022, at approximately 10:40 a.m., (unlicensed personnel) ULP-C was observed checking R1's blood glucose.	01960		

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01960	Continued From page 45 On June 23, 2022, at approximately 1:38 p.m., registered nurse (RN)-A confirmed staff monitored R1's blood glucose four (4) times a day and documented the results in RTasks (electronic health charting system). RN-A confirmed R1's prescriber orders directed to check R1's blood glucose three (3) times a day and thought there was an order in place to check R1's blood glucose at 11:00 a.m. RN-A stated R1 probably requested to have her blood glucose checked four times a day but R1's record lacked prescriber orders for blood glucose monitoring four (4) times a day. The licensee's undated Content of Medication Prescriptions and Treatment or Therapy Orders policy indicated treatment or therapy orders must be dated, signed by the prescriber and must be current and consistent with the client's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable	02310		

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02310	Continued From page 46	02310		

health care and medical, or nursing standards for two of two residents (R1, R2) with an assistive device, and one of one resident (R3) with a hospital bed with bed rails.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

This resulted in an immediate correction order on June 21, 2022.

The finding include:

On June 21, 2022, at approximately 1:17 p.m., registered nurse (RN)-A stated the licensee's Side-Rail Use Assessment Form did not include measurements of the side rails and further stated she was not aware measurements needed to be included. RN-A stated R2 had a siderail assessment completed and stated R1 and R3 records lacked evidence a side rail assessment had been completed or was provided risk vs. benefits on the use of siderails.

ASSISTIVE DEVICE
R1
On June 23, 2022, at approximately 2:00 p.m., the surveyor and RN-A observed and RN-A confirmed R1's bed to have a single rectangular shaped device, on the right upper side of the bed in an upright position. The device was not affixed to the bed; however, had two metal looped extension bars underneath the mattress that was

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02310	Continued From page 47 secured with Velcro to the bed frame. The device had an opening under 4 inches and fit snug against the mattress. R1's diagnoses included schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), obesity, macular degeneration (an eye disease that causes vision loss), hypertension (high blood pressure), and diabetes. R1's Service Plan dated February 1, 2022, indicated R1 received services including dressing, grooming, bathing, medication administration, laundry and housekeeping. R1's medical record lacked documentation of a bedrail assessment to ensure the device was safe and further lacked the risk vs. benefits associated with the use of bedrails. In addition, R1's record lacked documentation the device was installed per manufacture's guidelines. R2 On June 21, 2022, at approximately 2:04 p.m., the surveyor and RN-A observed and RN-A confirmed R2's bed to have a single metal rectangular device on the left side of the bed. \The device was not affixed to the bed; however, had a metal looped bar tucked under the mattress, and was secured with Velcro to the bed frame with a piece of plywood under the mattress. R2 diagnoses included schizo-affective disorder, post-traumatic stress disorder, traumatic brain injury (TBI), osteoarthritis, and anxiety. R2's Service Plan dated December 16, 2021, indicated R2 received services including dressing, grooming, bathing, medication administration, laundry and housekeeping.	02310		

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02310	Continued From page 48 R2's record included education on the risks and benefits associated with the use of bedrails dated December 11, 2018; however, lacked documentation of a bedrail assessment to include the bedrail was installed per manufacturer's instructions and was not recalled. HOSPITAL BEDS On June 21, 2022, at approximately 2:12 p.m., the surveyor observed RN-A measure R3's left sided hospital rail which was up against the wall. The bed rail on the right side of the bed was in the down position, and the left bed rail was in upright position. The opening between the bars for zone 1, measured 3-4 ½ inches. There were no measurable gaps between the mattress and the bedrail for zone 3. The measurements between the top of the bedrail to the headboard for zone 6, measured 3 ½ inches. R3's diagnoses included morbid obesity, depression, anxiety, diabetes, lymphedema, and (swelling in an arm or leg caused by a lymphatic system blockage). R3's Service Plan dated December 16, 2021, indicated R3 received services including grooming, bathing, treatments, medication administration, laundry and housekeeping. R3's medical record lacked documentation of a bedrail assessment to ensure the device was safe and further lacked the risk vs. benefits associated with the use of bedrails. In addition, R3's record lacked documentation the bedrail measurements met the FDA guidance. On June 21, 2022, at approximately 3:03 p.m.	02310		

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02310	Continued From page 49 RN-A verified R2's assistive device attached to R2's bed was manufactured by Bed Handles, Inc, model number AJ1, which had been recalled by the Consumer Product Safety Commission (CPSC) due to entrapment hazard and posed a risk of asphyxia. The licensee's undated Assessing The Safety Of Side Rails policy indicted the RN would assess and evaluate what the client's needs are and assess to determine if the client can safely utilize the side rail/equipment and determine whether the side rail meets the FDA standards for side rails. The policy further indicated the RN would provide for any client who has a side rail or is considering obtaining one and, if appropriate, the RN would educate the client's representative and/or client's family regarding side rail safety and risks including potential death due to falls, entrapment, and asphyxiation. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain,	02310		

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02310	Continued From page 50 uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days Immediacy was removed as confirmed by survey'rs on-site observations and review by evaluation supervisor on June 22, 2022, however, non-compliance remains at a level three widespread scope (I).	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph	03000		

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03000	Continued From page 51 (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for unaccounted controlled medication and complete a thorough investigation for one of one resident (R4) with records reviewed. This practice resulted in a level two violation (a	03000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03000	Continued From page 52	03000		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R4's diagnoses included anxiety, bipolar one (a form of mental illness), hypothyroidism (low thyroid level), chronic knee pain

R4's Service Plan (Waiver)-Addendum dated December 23, 2021, indicated R4 received medication management services.

On June 7, 2022, R4 was prescribed Codeine-Guaifen (a cough suppressant and expectorant which contains a narcotic)10 milliliter (ml) every six hours as needed for a cough.

On June 21, 2022, at approximately 10:50 a.m. the surveyor observed the locked narcotic box located in the medication cart with registered nurse (RN)-A. R4 had a bottle of Codeine-Guaifen with approximately 20 ml left in the bottle. R4's Narcotic Count Sheet indicated there was 40 ml of medication that had been unaccounted for.

On June 21, 2022, at approximately 10:55 a.m., RN-A stated she was told R4's Codeine-Guaifen count was off by 40 ml about a week prior. RN-A stated she reconciled the medication by making a dose correction on R4's Narcotic Count Sheet to reflect the amount of liquid medication that was in the bottle at that time. RN-A verified R4's Narcotic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30315	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCCARTHY MANOR INC	2221 NORTH ARLINGTON AVENUE DULUTH, MN 55811

(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
03000	Continued From page 53 Count Sheet indicated there should have been 150 ml left in R4's Codeine-Guaifen at the time the discrepancy was discovered but there was only 110 ml, which indicated 40 ml of R4's medication was missing and unaccounted for. RN-A confirmed she did not complete an investigation to determine if there was any theft or drug diversion, nor called and reported the missing narcotic to MAARC (Minnesota Adult Abuse Reporting Center). RN-A confirmed the stored narcotics were not being regularly counted and she completed audits on the narcotic counts every other week. RN-A confirmed the licensee's Loss or Spillage of Medication Including Controlled Medications was not followed. The licensee's undated Loss or Spillage of Medication, Including Controlled Medications indicated when loss or spillage of any medication occurs, notation must be made in the client's medication record explaining the spillage and the actions taken. If the loss or spillage was a controlled medication, the notation about the loss or spillage must be signed by the person responsible and one witness. The agency was required to take appropriate action under the federal or state regulations for any loss of unaccounted prescription drugs when theft or diversion was suspected. If theft or diversion was suspected, documentation would include the investigations and findings. If theft or diversion of prescription drugs was suspected, it must be reported to local law enforcement and may require a report to the MAARC (Minnesota Adult Abuse Reporting Center). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30315	A. BUILDING: _____ B. WING _____	06/23/2022

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Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *06/22/22*
Time: 11:30:00
Report: 1016221110

Food and Beverage Establishment Inspection Report

Location:
Mccarthy Manor Inc
2221 North Arlington Avenue
Duluth, MN55811
St. Louis County, 69

Establishment Info:
ID #: 0038938
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187221501
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13A ** Priority 2 **

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

A THERMOMETER WAS NOT AVAILABLE FOR TESTING DISH WASHER RINSE CYCLE. OBTAIN A WATER PROOF THERMOMETER OR COLOR CHANGE STICKERS.

Comply By: 06/24/22

Surface and Equipment Sanitizers

Hot Water: = at 162 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: RICE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 155 Degrees Fahrenheit - Location: CORN
Violation Issued: No

Process/Item: Hot Holding
Temperature: 161 Degrees Fahrenheit - Location: TACO MEAT
Violation Issued: No

Type: Full
Date: *06/22/22*
Time: 11:30:00
Report: 1016221110
Mccarthy Manor Inc

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

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

COMMENTS:

ESTABLISHMENT SHOULD BE COOKING FOOD FOR SAME DAY CONSUMPTION.

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016221110 of 06/22/22.

Certified Food Protection Manager: BRANDON J BARCLAY

Certification Number: FM108711 Expires: 11/11/24

Signed: _____
BRANDON BARCLAY
KITCHEN MANAGER

Signed: _____
Cliff LaVigne
Sanitarian
Duluth
2183026181
clifford.lavigne@state.mn.us