Electronically Delivered

January 5, 2022

Administrator
Evergreen Knoll
1309 14th Street
Cloquet, MN 55720

RE: Project Number(s) SL24494015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 2, 2021, 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), immediate fine imposition is authorized for both surveys and investigations conducted. 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, no immediate fines are assessed.

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. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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.

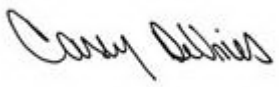
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. 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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,



Casey DeVries, Supervisor
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State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24494	A. BUILDING: _____ B. WING _____	12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN KNOLL	1309 14TH STREET CLOQUET, MN 55720

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been 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#24494015 On, November 30, 2021 through December 2, 2021 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 fifty-nine (59) residents receiving services under the provider's Assisted Living with Dementia Care license.	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 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all fifty-nine (59) residents residing at 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, 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated November 30, 2021.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure development of an individual abuse prevention plan with the required content for two of four residents (R1, R2) 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:	0 630		

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0 630	Continued From page 3 R1's diagnoses included chronic obstructive pulmonary disease (COPD) (a condition involving constriction of the airways and difficulty or discomfort in breathing) and Type II diabetes mellitus. R1's service plan dated October 22, 2021, indicated R1 received services which included medication administration, assistance with oxygen, nebulizer treatments, glucose checks and safety checks. R1's Individual Abuse Prevention Plan dated October 29, 2021, identified areas of vulnerability with interventions in the following areas: inability to safely evacuate without assistance, balance problems with walking and standing and general safety. R1's assessment dated October 29, 2021, did not include a review of R1's risk of abusing other vulnerable adults, susceptibility to be abused by another individual, including other vulnerable adults or statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2's diagnoses included macular degeneration, congestive heart failure and bilateral hearing deficits. R2's service plan dated November 12, 2021, indicated R2 received services which included medication administration, assistance with continuous positive airway pressure (CPAP) (a form of positive airway pressure), daily monitoring of weight and blood pressure, compression stockings, safety checks and personal assistance. R2's Individual Abuse Prevention Plan dated November 24, 2021, identified areas of	0 630		

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0 630	Continued From page 4 vulnerability with interventions in the following areas: inability to safely evacuate without assistance, decreased muscular coordination, impaired judgement and general safety that includes the use of safety alarms. R2's assessment dated November 24, 2021, did not include a review of R2's risk of abusing other vulnerable adults or susceptibility to be abused by another individual, including other vulnerable adults. On December 1, 2021, at 9:38 a.m., registered nurse (RN)-A confirmed R1's and R2's Individual Abuse Prevention Plans did not address the above noted areas of risk. The licensee's Abuse Prevention Plan policy, undated, noted the licensee would develop and implement an individual abuse prevention plan for all residents admitted to licensee's facility. The individualized plan would address specific resident needs and include safety goals to address the resident's ability. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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	0 680		

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0 680	Continued From page 5 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 develop a written emergency preparedness disaster plan with all the required content. This had the potential to affect all fifty-nine (59) residents receiving services under the assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 6 During the entrance conference on November 30, 2021, at approximately 10:45 a.m., a Minnesota Department of Health (MDH) surveyor requested to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. The licensee's plan did not include the following required content: - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; - the facilities role in providing care and treatment at alternative sites. - emergency preparedness training and testing program - emergency preparedness training program for staff (including documentation of training provided) - emergency preparedness testing/annual testing requirements On December 1, 2021, at approximately 11:50 a.m., licensed assisted living director (LALD)-B confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. The licensee's Disaster policy, undated, noted the facility would develop facility specific disaster policies.	0 680		

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0 680	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 facility failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety and well-being of the residents. This had the potential to directly affect all fifty-nine (59) 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 December 1, 2021, between 10:00 a.m. and 12:30 p.m., survey staff toured the facility with	0 800		

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0 800	Continued From page 8 property maintenance (PM)-E. During facility tour, survey staff made the following observations: 1. Supplies were stored in mechanical rooms blocking access to electrical panels on the first and second floors. During facility tour interview with PM-E, it was confirmed that the mechanical rooms were being used for storage and that electrical panels were obstructed. 2. Three fire doors did not auto-latch shut when tested on first and second floors. During facility tour interview with PM-E, it was confirmed that the fire doors did not auto-latch shut and required repair. 3. The dementia care dining room floor on the second floor was peeling, creating a trip/fall hazard for residents. During exit interview with PM-E at approximately 1:35 p.m., it was confirmed that the dining room floor was damaged and required repair or replacement. 4. The dementia care laundry room door was propped open and not staffed on the second floor during facility tour. This laundry room contained one unlocked electrical control panel. During exit interview with PM-E at approximately 1:35 p.m., it was confirmed that the laundry room door was propped open during the facility tour and should be kept locked. 5. Items were stored on shelves directly under fire sprinklers in several storage areas and in the laundry room on the first floor. During facility tour interview with PM-E, it was confirmed that items were stored too close to fire sprinklers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 9 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, facility failed to provide the required employee evacuation drill frequency and resident training. This had the potential to affect all fifty-nine (59)	0 810		

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0 810	Continued From page 10 residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 1, 2021 at 12:30 p.m., records were provided for review by the licensed assisted living director (LALD)-B and property maintenance (PM)-E. On December 1, 2021, between 12:30 p.m. and 1:10 p.m., records were reviewed by survey staff. These records included the Evergreen Senior Living Emergency Plan dated April 2016 and an employee training record. 1. Licensee failed to provide the required frequency for staff evacuation drills. Evacuation drills were conducted yearly. 2. Licensee failed to provide annual fire safety and evacuation training for residents. On December 1, 2021, between 1:25 p.m. and 1:45 p.m., LALD-B confirmed during exit interview that the facility failed to provide annual fire safety and evacuation training for residents and that the required frequency for staff evacuation drills was not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 980 SS=F	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident agreement arbitration requirement did not include language that stops, limits, or delays the resident from filing a lawsuit against the facility. This affected four of four residents (R1, R2, R3 and R4) with records reviewed and had the potential to affect all fifty-nine (59) 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: R1 and R2's Assisted Living Resident Agreement signed October 22, 2021, and November 12, 2021, respectively included in section 32.0 Arbitration "The Arbitration Agreements provides	0 980		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN KNOLL	1309 14TH STREET CLOQUET, MN 55720

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0 980	Continued From page 12 that, except as specifically provided, controversies, disputes, disagreements, and claims arising from or relating to this Agreement and personal injury claims by Resident against Facility relating to alleged malpractice, inadequate care, or any other cause or reason shall be settled exclusively by binding arbitration. This means that Resident will not be able to file a civil action in any court to resolve such claims or disputes. The Agreement also included an Arbitration Agreement [exhibit J] and under XI noted "Resident acknowledges and understands that there will be no jury trial on any claim or dispute submitted to binding arbitration and that, by signing this Arbitration Agreement, Resident relinquishes and gives up his or her rights to a jury trial on any matter submitted to binding arbitration." R3 and R4's Assisted Living Resident Agreement signed July 26, 2021, and August 5, 2021, respectively included in section 32.0 Arbitration "The Arbitration Agreements provides that, except as specifically provided, controversies, disputes, disagreements, and claims arising from or relating to this Agreement and personal injury claims by Resident against Facility relating to alleged malpractice, inadequate care, or any other cause or reason shall be settled exclusively by binding arbitration. This means that Resident will not be able to file a civil action in any court to resolve such claims or disputes. The Agreement also included an Arbitration Agreement [exhibit J] and under XI noted "Resident acknowledges and understands that there will be no jury trial on any claim or dispute submitted to binding arbitration and that, by signing this Arbitration Agreement, Resident relinquishes and gives up his or her rights to a jury trial on any matter submitted to binding arbitration."	0 980		

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0 980	Continued From page 13 On December 1, 2021, at approximately 3:50 p.m., licensed assisted living director (LALD)-B and registered nurse (RN)-A confirmed the Assisted Living Resident Agreement was a document that was developed by a law firm for the licensee. LALD-B confirmed this assisted living contract was a template contract used for all residents at the facility. LALD-B stated the contract language could be clarified more to meet the regulations. On November 30, 2021, at approximately 11:30 a.m., RN-A provided the licensee's policy book. The licensee lacked a policy regarding the development and execution of an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 980		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of two residents (R4) with records reviewed.	01770		

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01770	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on November 30, 2021, at approximately 11:05 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services, including medication setup. R4's diagnoses included anxiety, glaucoma, spinal stenosis (narrowing of the spinal canal which can put pressure on the spinal cord and the nerves within the spine), and neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet). R4's service plan and medication management plan dated August 13, 2021, and September 15, 2021, respectively, indicated R4 received medication management services. R4's prescriber orders dated April 29, 2021, included an order for hydrocodone/APA 5-325 milligrams (mg) (a narcotic to treat severe pain) to be administered every six (6) hours as needed for pain. On November 30, 2021, at approximately 11:55 a.m., the "assisted living medication cart" was reviewed with RN-A. In the double locked narcotic box, the surveyor observed a blister pack (a	01770		

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01770	Continued From page 15 transparent, molded piece of plastic, often sealed to a sheet of cardboard, used to package tablets) of hydrocodone/APA 5-325 mg for R4. On the back of the blister pack, it was noted four (4) blister pack seals had been broken and the seals taped back up with red "tamper resistant" tape on the back of the blisters for the tablets in #8, #25, #29, and #30 blisters. Each taped blister seal was initialed [RN-A]. RN-A confirmed she had setup these four hydrocodone/APA tablets. RN-A confirmed she did not document this medication setup to include documentation of the dates of the medication setup, the name of the medication, quantity of dose, times to be administered, and the route of administration at the time she setup the medications as required. The licensee's Medication Administration System-Dosage Box Set-up policy, undated, noted the RN or licensed practical nurse/LPN would setup medications. The licensee's policy did not include specific verbiage regarding how medication setup would be documented in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
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	01880		

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01880	Continued From page 16 by: Based on observation, interview, and record review, the licensee failed to maintain one of one medication refrigerator at an acceptable temperature to ensure medications were stored according to manufacturer's recommendations. This had the potential to affect all fifty-nine (59) 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: On November 30, 2021, at approximately 1:50 p.m., the surveyor observed the locked medication refrigerator located in the secure nursing office with registered nurse (RN)-A. RN-A confirmed the current temperature of the refrigerator was 37.6 degrees Fahrenheit (F). RN-A stated the temperature was monitored each shift and recorded in the licensee's electronic record. The refrigerator contained, but was not limited to, the following medications: - three (3) unopened Novolog 100 units/milliliters (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for resident (R)9 - three (3) unopened Basaglar 100 units/ml insulin pens for R9 - two (2) unopened Basaglar 100 units/ml insulin pens for R10 - three (3) unopened aspart (generic Novolog) 100 units/ml insulin pens for R6	01880		

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01880	Continued From page 17 - six (6) unopened Lantus 100 units/ml insulin pens for R11 The manufacturer's instructions for Novolog (aspart) insulin pens dated November 2019, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze. The manufacturer's instructions for Basaglar insulin pens dated December 2015, indicated unopened pens should be stored in the refrigerator at 36 to 46 degrees F. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not allow to freeze. On November 30, 2021, at approximately 2:30 p.m., RN-A provided the medication refrigerator temperature logs dated November 1, 2021, through November 30, 2021. The medication refrigerator temperature had been monitored three times a day (89 times); 22 of the 89 times the refrigerator temperature was recorded as below 36 degrees F. RN-A confirmed the above noted temperature readings were not within the acceptable range. The licensee's Central Storage of Medications or Secure Storage of Medications policy, undated, noted medications kept in central or secured storage must be kept in locked compartments under proper temperature controls. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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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, licensee failed to date time-sensitive medications with an opened on date for three of three residents (R1, R6 and R8), and the licensee failed to ensure medication containers had the original prescription label for one of one resident (R8). 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 November 30, 2021, at approximately 11:45 a.m., a tour of the facility was conducted with registered nurse (RN)-A, including a review of the three medication carts. The following was observed, and confirmed with RN-A: TIME SENSITIVE MEDICATIONS	01890		

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01890	Continued From page 19 R1's opened Anoro Ellipta 62.5 micrograms (mcg)/25 mcg inhaler (bronchodilator) lacked a date the inhaler had been removed from the foiled packaging and when the inhaler would expire. R6's opened Lantus (long-acting insulin) 100 unit/milliliter (ml) insulin pen lacked the date the pen had been opened and when the pen would expire. R8's opened Trelegy Ellipta 100/62.5/25 mcg inhaler (corticosteroid) lacked a date the inhaler had been removed from the foiled packaging and when the inhaler would expire. ORIGINAL PRESCRIPTION LABELS R8's opened Trelegy Ellipta 100/62.5/25 mcg inhaler lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. The manufacturer's instructions for the Anoro Ellipta inhaler dated October 2020, directed to discard the inhaler six (6) weeks after opening the foil tray or when the counter reads "0", whichever comes first. 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 the Trelegy Ellipta inhaler dated January 2019, directed to discard the inhaler six (6) weeks after opening the foil tray.	01890		

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01890	Continued From page 20 On November 30, 2021, at approximately 11:50 a.m., RN-A confirmed all medications should have original labels and the above time sensitive medications should be dated after opening with an open and expiration date. The licensee's Central Storage of Medications or Secured Storage of Medications policy, undated, noted a legend drug would be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of the drug, strength and quantity of the drug, expiration date of a time-dated drug, directions for use, resident's name, the prescriber's name, the date of issue, and the name and address of the dispensing pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01920 SS=F	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	01920		

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01920	Continued From page 21 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 develop and implement procedures for loss and spillage of all controlled substances defined in Minnesota Rules part 6800.4220. This had the potential to affect all fifty-nine (59) 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: During the entrance conference on November 30, 2021, at approximately 11:05 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services, including storage of controlled substances. On November 30, 2021, at approximately 11:30 a.m., RN-A provided the licensee's policy book. The policies provided by RN-A did not include a policy/procedure for loss or spillage of controlled substances as required. On November 30, 2021, at approximately 11:55 a.m., the licensee's secure storage of controlled	01920		

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01920	Continued From page 22 substances was observed with RN-A. On December 2, 2021, at approximately 8:55 a.m., RN-A verified the licensee had not developed a policy to address loss or spillage of controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01920		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a hazard vulnerability or safety risk assessment for the facility. This had the potential to affect all dementia care 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 is issued at a	02040		

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02040	Continued From page 23 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 December 1, 2021, at approximately 12:30 p.m., the licensed assisted living director (LALD)-B and property maintenance (PM)-E provided records for review. The Evergreen Senior Living Emergency Plan dated April 2016 was reviewed. A hazard vulnerability or safety risk assessment for the facility was not included in the records provided. On December 1, 2021, between 1:25 p.m. and 1:45 p.m., during exit interview, LALD-B confirmed that the licensee failed to complete a hazard vulnerability or safety risk assessment on and around the property. It was discussed during exit interview that the kitchens in the dementia care units were provided with stoves connected to power and these areas were not secure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided	02110		

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02110	Continued From page 24 based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representative at the time of move-in. This practice resulted in a level one violation (a	02110		

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02110	Continued From page 25 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative. The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 92 residents. On December 1, 2021, at 11:25 a.m., the licensed assisted living director (LALD)-B confirmed the inclusive list of dementia care policies and procedures had not been provided to each resident and/or representative. On December 2, 2021, 9:30 a.m., registered nurse (RN)-A verified several of the dementia care policies had recently been developed and had not been distributed to the residents and/or their representative. The licensee lacked a policy regarding the procedure for how the dementia care policies would be distributed to each resident and/or representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

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

Type: Full
Date: *11/30/21*
Time: 10:40:00
Report: 1027211114

Food and Beverage Establishment Inspection Report

Location:
Evergreen Knoll
1309 14th Street
Cloquet, MN55720
Carlton County, 09

Establishment Info:
ID #: 0014915
Risk: Medium
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:
HADC Services, LLC Cloquet

Phone #: 2188783302
ID #: 17688

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

PROVIDE CHLORINE TEST STRIPS FOR MEASURING SANITIZER STRENGTH OF DISH MACHINE.

Comply By: 12/21/21

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

THERE WAS NOT THERMOMETER IN UPRIGHT FREEZER IN KITCHEN AT TIME OF INSPECTION. MANAGER STATED A THERMOMETER WAS BEING ORDERED FOR FREEZER. PROVIDE THERMOMETER.

Comply By: 12/14/21

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

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

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

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

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

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

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

Process/Item: Upright Cooler
Temperature: 32 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

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

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

DISCUSSED REQUIRED TIMES AND TEMPS FOR COOLING, REQUIRED SANITIZER LEVELS, HOW BARE HAND CONTACT IS BEING LIMITED, AND EMPLOYEE ILLNESS AND EXCLUSIONS WITH KITCHEN MANAGER. MANAGER STATED LIQUID PASTEURIZED EGGS ARE USED WHEN POOLING EGGS FOR SCRAMBLED EGGS FOR RESIDENTS.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MN Department of Health inspection report number 1027211114 of 11/30/21.

Certified Food Protection Manager: TAYLOR GUSTAFSON

Certification Number: FM106768 Expires: 06/08/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
TAYLOR GUSTAFSON
MANAGER

Signed: Ian Harrison
Ian H

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