Electronically Delivered

May 11, 2023

Licensee
Virginia Carefree Living
421 10th Street South
Virginia, MN 55792

RE: Project Number(s) SL33023015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 26, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33023	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA CAREFREE LIVING	421 10TH STREET SOUTH VIRGINIA, MN 55792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33023015-0 On April 25, 2023, through April 26, 2023, 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 35 active residents; all receiving services under the 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 25, 2023 for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810		

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0 810	Continued From page 2 (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, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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 potential to affect a large portion or all of	0 810		

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0 810	Continued From page 3 the residents). A record review of available documentation and interview were conducted on April 25, 2023, at approximately 10:15 a.m. of documents provided by maintenance (M)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not have detailed fire protection procedures necessary for residents located within the plan. At the time of the interview fire protection procedures for residents was verbally presented by M-F but the information was not included in writing in the fire safety and evacuation plan. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. At the time of the interview training materials were presented and it was stated by M-F the training was completed but the written documentation was not available. Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. At the time of the interview training materials were presented and it was stated by M-F the training was offered but the written documentation was not available. All deficiencies were verified by M-F during the	0 810		

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0 810	Continued From page 4 interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of 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 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).	0 820		

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0 820	Continued From page 5 Findings include: On a facility tour of the memory care unit on April 25, 2023, at approximately 12:00 p.m. with maintenance (M)-F, it was observed an exterior exit gate from the secure fenced outdoor area was provided with padlock hardware and a padlock for security. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors. All clinical staff are required to carry a key or keypad combination to release the latch of the secured gate for egress. This deficient condition was verified by M-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices;	01370		

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01370	Continued From page 6 (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of two unlicensed personnel (ULP-D) to include all required content. 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	01370		

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01370	Continued From page 7 a large portion or all of the residents). The findings include: ULP-D was hired on October 17, 2022, to provide direct care services to residents at the assisted living with dementia facility. On April 26, 2023, at 7:44 a.m., the surveyor observed ULP-D complete medication administration for R3. ULP-D's employee record did not include documentation of training for the following: -basic nutrition, meal preparation and food safety. On April 26, 2023, at 11:52 a.m., registered nurse (RN)-G confirmed ULP-D had not completed the above noted training as required. RN-G stated the facility was recently made aware this training was not included in their new hire system for any of their ULPs. RN-G added ULP-D was scheduled to take this class in June 2023. The licensee's Training and Competency of Unlicensed Staff policy, revised January 16, 2023, noted training and competency evaluations for all unlicensed personnel must include basic nutrition, meal preparation, food safety, and assistance with eating. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 8 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee and first performed delegated tasks for one of one unlicensed personnel (ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01440		

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01440	Continued From page 9 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 26, 2023, at 7:44 a.m., the surveyor observed ULP-D complete medication administration for R3. ULP-D was hired on October 17, 2022, to provide direct care services to residents at the assisted living with dementia facility. ULP-D's employee record included a Support & Corporate Employee Evaluation form dated January 16, 2023, which included the following categories: -job knowledge, dependability, initiative, safety, productivity, communication, appearance, and goals. ULP-D's record did not include documentation of a registered nurse (RN) supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee. On April 26, 2023, at approximately 11:15 a.m., RN-G confirmed ULP-D's 30-day supervision of performing a delegated task had not been completed as required. RN-G later brought the surveyor a blank form which RN-G stated the facility uses, which included a section for delegated task supervision. RN-G stated ULP-D's record was missing part of the form the facility used confirming ULP-D had not been supervised by an RN while completing a delegated task. On May 4, 2022, at 11:58 a.m., clinical nurse supervisor (CNS)-C confirmed ULP-D's 30-day supervision of performing a delegated task had	01440		

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01440	Continued From page 10 not been completed as required. The licensee's Delegation of Nursing, Treatment or Therapy Tasks policy, revised January 16, 2023, noted the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working for the facility and first performed the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500		

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01500	Continued From page 11 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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:	01500		

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01500	Continued From page 12 Based on observation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two employees (clinical nurse supervisor, (CNS)-C). 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: CNS-C started employment on October 6, 2021. On April 26, 2023, at approximately 8:30 a.m., the surveyor observed CNS-C on the secured unit talking with unlicensed personnel (ULP)-D. CNS-C's employee record lacked evidence CNS-C successfully completed annual training as required to include: -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On April 25, 2023, at 3:16 p.m., CNS-C stated she would look for the missing training items from her record. On April 25, 2023, at approximately 3:45 p.m.,	01500		

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01500	Continued From page 13 CNS-C stated she was not able to find any other training records for herself. CNS-C confirmed her record was missing the above required training. The licensee's Training and Competency of Unlicensed Staff policy, revised January 16, 2023, noted all staff providing direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

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01620	Continued From page 14	01620		

individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment not to exceed14 days from the date of admission for one of three residents (R2) and the licensee failed to ensure the registered nurse completed a comprehensive assessment not to exceed 90 days for three of three residents ((R2, R3, R4).

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

The findings include:

14-DAY AND 90-DAY ASSESSMENTS

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01620	Continued From page 15 R2 R2's diagnoses included unspecified dementia without behavioral disturbance, dysphagia (difficulty swallowing) and malaise (a feeling of weakness, overall discomfort, illness, or simply not feeling well). R2's service plan dated August 16, 2022, indicated R2 required assistance with medication management, eating, incontinence, escorts, safety checks, transfers, bed mobility, dressing, grooming, laundry, and housekeeping. On April 25, 2023, at 7:24 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's morning medication. R2's Admission Assessment and 14-Day Assessment was completed on July 29, 2022, and August 30, 2022, respectively for a total of 32 days in between assessments. R2's 14-day assessment and first 90-day assessment was completed on August 30, 2022, and December 10, 2022, respectively for a total of 102 days in between assessments. R2's 90-day assessments were completed on December 10, 2022, and March 14, 2023, respectively for a total of 93 days in between assessments. R3 R3's diagnoses included dementia without behavioral disturbances, type two diabetes, adjustment disorder with mixed disturbance of emotions and conduct. R3's service plan dated November 1, 2022, indicated R3 required assistance with medication	01620		

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management, behavior interventions, incontinence, escorts, safety checks, transfers, dressing, grooming, laundry, and housekeeping.

On April 26, 2023, at 7:44 a.m., the surveyor observed ULP-D administer R3's oral and topical morning medications.

R3's 90-Day Assessments were completed on January 8, 2023, and April 10, 2023, respectively for a total of 92 days in between assessments.

R4
R4's diagnoses included dementia without behavioral disturbances, type two diabetes, major depressive disorder, and dry eye syndrome.

R4's service plan dated August 30, 2022, indicated R4 required assistance with medication management, blood glucose monitoring, dressing, bathing, laundry, and housekeeping.

On April 26, 2023, at 8:08 a.m., ULP-L was observed administering R4's scheduled insulin, eye drops and oral medications.

R4's 90-Day Assessments were completed on November 13, 2022, and February 17, 2023, respectively for a total of 96 days in between assessments.

On April 27, 2023, at 11:02 a.m., clinical nurse supervisor (CNS)-C verified R2's 14-Day assessment, and R2, R3 and R4's 90-Day Assessments were not completed within the required timeframe.

The licensee's Assessments, Reviews, and Monitoring Policy revised January 16, 2023, indicated resident reassessment and monitoring

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01620	Continued From page 17 must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the assessment. In addition, the assessment or reassessment must include all the elements of the uniform assessment tool as required. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	01640		

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01640	Continued From page 18 the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of three residents (R2) service plans were revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:) R2's diagnoses included unspecified dementia without behavioral disturbance, dysphagia (difficulty swallowing) and other malaise (a feeling of weakness, overall discomfort, illness, or simply not feeling well). R2's service plan dated August 16, 2022, indicated the resident required assistance with dressing and undressing, grooming, bed mobility, escorts within the building, was dependent with toileting, and eating assist. COMPRESSION STOCKINGS (TEDS) On April 26, 2023, at 7:29 am., the surveyor observed unlicensed personnel (ULP)-D administer R2's oral medications in the dining area. R2 was sitting in a wheelchair and R2 was wearing TEDs.	01640		

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01640	Continued From page 19 R2's provider's note dated March 7, 2023, at 8:29 a.m., noted compression stocking 15-20 mmHg (millimeters of mercury/ indicates the level of pressure or compression), on in a.m. (morning), off at h.s (hour of sleep), two pair. R2's medication administration record (MAR) dated April 1, 2023, through April 25, 2023, included anti-embolism (TEDs) sm/reg (small/regular), wear daily, on in the morning and off in the evening wash after removing at bedtime, hang to dry. On April 26, 2023, at 10:55 a.m., clinical nurse specialist (CNS)-C confirmed R2's service plan should have included TEDs. THICKENED LIQUIDS On April 26, 2023, at approximately 7:30 a.m., the surveyor observed ULP-D take an empty glass and put some cranberry juice in it. ULP-D then brought the glass with juice in it to the locked medication cart. ULP-D opened the bottom drawer of the medication cart and removed a large container of Thick-it (product which allows you to modify liquids and pureed foods to help people with swallowing problems). ULP-D then placed the thickened cranberry juice in front of R2. R2's provider's note dated April 4, 2023, at 1:55 p.m., noted trial Thick-it prn (as desired or needed) for liquids. R2's progress note dated April 4, 2023, at 1:59 p.m., written by licensed practical nurse (LPN)- B, noted "order Thick-it to fluids to achieve desired consistency". R2's provider's note dated April 25, 2023, at 8:37	01640		

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01640	Continued From page 20 a.m., noted "doing well with Thick-it". R2's MAR dated April 7, 2023, to April 25, 2023, included, Thick-it Powder original (starch-maltodextrin), use to thicken liquids to achieve desired consistency, use to thicken fluids, follow directions on the container, 3 scoops into fluids. On April 26, 2023, at 10:56 a.m., registered nurse (RN)-G stated R2's service plan should have been updated to include Thick-it. The licensee's Service Plan policy revised January 16, 2023, indicated the service plan and any revisions shall include a signature or other authentication by the facility and by the resident, or resident's representative, documenting agreement on the services to be provided. Service plans shall be revised, if needed, based on resident reassessments and monitoring. In addition, service plans and any revisions or updates shall be entered into the resident's record, including notice of change in fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for three of four residents (R2, R3, R5).

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:

MEDICATIONS GIVEN AS ORDERED
ORAL
R2
R2's diagnoses included unspecified dementia without behavioral disturbance, dysphagia (difficulty swallowing) and other malaise (a feeling of weakness, overall discomfort, illness, or simply not feeling well).

R2's service plan dated August 16, 2022, indicated R5 received medication administration.

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01760	Continued From page 22 On April 25, 2023, at 7:24 a.m., the surveyor observed unlicensed personnel (ULP)-D removed two (2) acetaminophen 500 milligrams (mg), Lexapro 2.5 mg, and levothyroxin 75 micrograms (mcg) from a locked medication cart. ULP-D crushed and administered these medications to R2. R2's medication administration record (MAR) dated April 1, 2023, through April 25, 2023, included: -acetaminophen 500 mg take two tablets by mouth twice daily, 8:00 a.m., 800 p.m.; -Lexapro take one-half tablet 2.5 mg by mouth daily, 8:00 a.m.; and -levothyroxine 75 mcg by mouth daily, 7:00 a.m. R2's providers orders dated January 18, 2023, included: - acetaminophen caplet 500 mg two (2) tablet, 1000 mg, by mouth twice daily, 8;00 a.m., 8:00 p.m.; -Lexapro 5 mg take one-half tablet 2.5 mg by mouth daily, 8:00 a.m.; and -levothyroxine 75 mcg daily, take one tablet by mouth daily, 7:00 a.m. On April 26, 2023, at 10:51 a.m., clinical nurse specialist (CNS)-C stated R2's medications should be given separately, the 7:00 a.m. medication and the 8:00 a.m. medication, as noted on the MAR. The manufacturer's instructions for levothroxine dated March 22, 2019, indicated levothyroxine should be taken at least 60 minuets before the first meal of the day or at bedtime (at least 3 hours after the evening meal).	01760		

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01760	Continued From page 23 ENSURE (NUTRITIONAL SUPPLEMENT) On April 25, 2023, at 11:52 a.m., the surveyor observed R2 sitting in a wheelchair which was pushed up to a table in the commons area. R2 was drinking an Ensure (nutritional supplement). R2's MAR dated April 1, 2023, through April 25, 2023, included Ensure Chocolate, drink 1 can twice daily between meals, 10:00 a.m., 7:00 p.m. R2's providers orders dated January 18, 2023, included Ensure chocolate, twice a day, drink one (1) can twice daily between meals, 10:00 a.m., and 7:00 p.m. On April 26, 2023, at 9:53 a.m., ULP-D stated, "I am just going to be straight up with you. We give her the Ensure at breakfast and then again at lunch because she doesn't drink a whole one." On April 26, 2023, at 11:00 a.m., CNS-C stated R2's Ensure was to be given in between meals, not with meals. TOPICAL MEDICATION R3 R3's diagnoses included dementia without behavioral disturbances, type two diabetes, adjustment disorder with mixed disturbance of emotions and conduct. R3's service plan dated November 1, 2022, indicated R3 required assistance with medication administration. On April 26, 2023, at 7:44 a.m., the surveyor observed ULP-D administer R3's oral medication. ULP-D then opened a dresser drawer and removed a clean pair of gripper socks. ULP-D then took the container of Sarna cream which	01760		

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was in R3's room and removed the gripper socks R3 had on and applied the Sarna cream to R3's lower legs and feet.

R3's April 1, 2023, through April 25, 2023, MAR included:
- Sarna apply to back twice daily for itching.

On April 26, 2023, at 11:03 a.m., CNS-C stated R3's MAR should be followed and Sarna cream should have been applied to R3's back.

TIMING OF MEDICATION
R5
R5's diagnoses included hyperlipidemia and hypertension.

R5's service plan dated February 1, 2023, indicated R5 received medication administration.

On April 26, 2023, at 7:23 a.m., the surveyor observed ULP-D remove 6 bottles of medication out of the locked medication cart, in the secured unit to include:
- a bottle labeled, atorvastatin 10, mg, to be given at bedtime.

Directly following the above observation, the surveyor observed ULP-D administer R5's medication.

On April 26, 2023, at approximately 7:30 a.m., ULP-D looked at the bottle of atorvastatin and at the MAR and stated the MAR noted to give "daily".

R5's providers orders dated December 27, 2022, included atorvastatin 10 mg daily.

On April 26, 2023, at 11:45 a.m., CNS-C

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01760	Continued From page 25 confirmed she was aware atorvastatin should be given in the evening. CNS-C stated there was a conversation that took place with R5's wife with a staff member. R5's wife told the unidentified staff that when at home she gave R5 all of his medications at the same time. The manufacturer's instructions for atorvastatin dated August 3, 2022, noted cholesterol production tends to be highest overnight, when the body is in a fasting state. Because of this, the recommendation for patients taking short-acting statins has been to take them right before bed for maximum effectiveness, and many studies have shown that these short acting statins are less successful at lowering cholesterol when taken at any other time of the day. The licensee's Training Unlicensed Personnel for Medication Administration policy revised January 16, 2023, indicated after the unlicensed personnel have met the qualifications in MN Statute 144G.61 and 144G.62 and have been competency tested the unlicensed personnel and have been delegated the task of medication administration or assistance with self-administration of medication: -the 6 RIGHTS of medication (right patient, right medication, right dose, right time, right route, right documentation); and -the complete procedure for checking a client's medication record and the nurse's written procedures specific to the client for the administration of any medication being managed by our agency. This includes procedures for administration of any over-the counter medications, PRN (as needed or as desired) medication or dietary supplements our agency had agreed to manage for the client.	01760		

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01760	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 medications were stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures for one (1) of one (1) medication refrigerator. In addition, the licensee failed to ensure medications were secured in a locked area for two (2) of four (4) residents, R3. R4. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: MEDICATION STORED ACCORDING TO MANUFACTURER'S RECOMMENDATIONS	01880		

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01880	Continued From page 27 On April 25, 2023, at 10:14 a.m., during a tour of the medication storage room the surveyor observed located outside of the medication refrigerator were recorded temperature logs from January 1, 2023, through April 25, 2023. Licensed practical nurse (LPN)-H verified the internal refrigerator thermometer indicated the current temperature of the medication refrigerator was 36 degrees Fahrenheit (F). LPN-H stated the unlicensed personnel (ULPs) were responsible for monitoring and recording daily medication refrigerator temperatures and confirmed the documented refrigerator logs indicated temperatures below 36 degrees F. The medication refrigerator temperature logs indicated the following: -February 1-28, 2023, indicated three (3) recorded temperatures below 36 degrees F; -March 1-31, 2023, indicated two (2) recorded temperatures below 36 degrees F; and -April 1-25, 2023, indicated five recorded (5) temperatures below 36 degrees F. The medication refrigerator temperature logs indicated temperatures should remain between 36-46 degrees F, and directed to contact the on-call nurse if found to be outside of range. On April 25, 2023, at 10:46 a.m., the surveyor and LPN-B observed and confirmed the contents of the medication refrigerator included the following medications: -one (1) opened bottle of gabapentin 250/5 milliliters (ml) solution (used to prevent seizures and nerve pain); -three (3) unopened Humalog Kwik insulin pens (fast-acting insulin); and -two (2) unopened Victoza 18 milligrams (mg)/3 ml (an injection used to control blood sugar levels).	01880		

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The manufacturer's instructions for gabapentin revised July 2010, directed to store liquid gabapentin in the refrigerator between 36-46 degrees F.

The manufacturer's instructions for Humalog Kwik insulin pen revised November 2019, directed to store unopened Humalog in the refrigerator between 36-46 degrees F.

The manufacturer's instructions for Victoza revised December 2022, directed to store unopened Victoza in the refrigerator between 36-46 degrees F.

On April 25, 2023, at 2:29 p.m., clinical nurse supervisor (CNS)-C verified the out-of-range medication refrigerator temperatures and stated she was not aware of the out of range temperatures. CNS-C stated the expectation of staff was to notify the nurse if the temperatures were out of range and further stated there was no documentation indicating the nurse had been notified.

SECURE MEDICATION STORAGE
R3
On April 26, 2023, at 7:44 a.m., the surveyor observed unlicensed personnel (ULP)-D remove R3's sertraline (depression) 50 mg from the locked medication cart in the secured unit. ULP-D reviewed R3's medication administration record (MAR) and commented out loud, R3's Sarna cream was in R3's room, "because Hospice uses it also."

Directly following the above observation, ULP-D went to R3's room and administered R3's oral medication. ULP-D then took the bottle of Sarna

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cream which was in R3's room and removed the gripper socks R3 had on and applied the Sarna cream to R3's lower legs and feet. ULP-D then applied a clean pair of gripper socks to R3's feet and placed the Sarna cream back to the location ULP-D got it from in R3's room.

R3's Medication Management Plan dated December 15, 2022, noted medications would be stored or secured, outside client's [residents] home in locked container. In addition, medication would be kept in locked medication cart, and overflow medications would be kept in locked medication locker inside the memory care nursing office.

On April 26, 2023, at 11: 05 a.m., CNS-C stated she was not aware R3's Sarna cream was stored in R3's room. CNS-C confirmed the Sarna cream was not to be left in R3's room.

R4
On April 26, 2023, at 8:10 a.m., the surveyor observed ULP-I apply R4's Betameth lotion (used to treat psoriasis) to R4's back which was kept in R4's room.

R4's 90-Day Assessment dated February 17, 2023, indicated R4's medications would be stored in a locked medication cart and an overflow of medications would be stored in the locked in the nurse's office.

On April 26, 2023, at 11:21 a.m., CNS-C stated R4 was not assessed to have any medications or creams to be kept at bedside and further stated all medications and creams should be stored in the medication cart or otherwise directed.

The licensee's Storage of Medication policy dated

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01880	Continued From page 30 January 16, 2023, indicated based on an assessment, the RN would develop an individualized medication management plan for the resident that would address storage of the resident's medications. In addition, all medications being managed by the licensee would be stored to manufacturer's directions. Medications needing refrigeration would be stored between 36-46 degrees Fahrenheit. The temperatures would be logged daily on a flow sheet and any temperatures outside of this range are to be reported to the nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration dates for R6. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01890		

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01890	Continued From page 31 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 entrance conference on April 25, 2023, at 9:39 a.m., clinical nurse supervisor (CNS)-C confirmed the licensee provided medication storage. On April 25, 2023, at 10:23 a.m., the surveyor observed the sucured care unit medication cart with unlicensed personnel (ULP)-D. ULP-D confirmed R6's Gentamicin 0.3% eye drop (treats bacterial infections) lacked the date the eye drop had been opened and would expire. ULP-D stated staff should be dating eye drops, inhalers, and insulins when first opened. The manufacturer's instructions for Gentamicin revised October 2020, indicated to discard after 28 days of opening. The licensee's Storage of Medication policy revised January 16, 2023, indicated time sensitive medications must indicate the date the medication would expire and stored consistent with the manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy	01950		

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01950	Continued From page 32 Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01950		

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01950	Continued From page 33 R2's diagnoses included unspecified dementia without behavioral disturbance, dysphagia (difficulty swallowing) and other malaise (a feeling of weakness, overall discomfort, illness, or simply not feeling well). R2's s service plan dated August 16, 2022, indicated the resident required setup and cueing with meals and eating assist. On April 26, 2023, at 7:28 am., the surveyor observed unlicensed personnel (ULP)-D go to the kitchen to get a small container of apple sauce. ULP-D moved the pill crusher to the front of the medication cart. ULP-D removed R3's morning medication from the locked medication cart in the secured unit and placed the medications into a small plastic bag and crushed the medication and added the medication to a small amount of applesauce and administer R3's morning medication at the dining room table where R3 was sitting. The surveyor observed R3 had a cup of coffee in front of her. Directly following the above observation ULP-D took an empty glass and put some cranberry juice in it. ULP-D then brought the glass with juice in it to the locked medication cart. ULP-D opened the bottom drawer of the medication cart and removed a large container of Thick-it (product which allows you to modify liquids and pureed foods to help people with swallowing problems). On the side of the Thick-it container handwritten in black marker it noted to add, 3 tbsp (tablespoon). ULP-D was not able to state if the juice should be at a nectar, honey, or pudding consistency. In addition, ULP-D stated R3's coffee had not been thickened, adding R3 doesn't drink much coffee now that Ensure (nutritional	01950		

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01950	Continued From page 34 supplement) has been added. R2's provider's note dated April 4, 2023, at 1:55 p.m., noted trial Thick-it prn (as desired or needed) for liquids. R2's progress note dated April 4, 2023, at 1:59 p.m., written by licensed practical nurse (LPN)- B, noted "order thick-it to fluids to achieve desired consistency". R2's provider's note dated April 25, 2023, at 8:37 a.m., noted doing well with Thick-it. R2's medication administration record (MAR) dated April 7, 2023, to April 25, 2023, included, Thick-it Powder original (starch-maltodextrin), Use to thicken liquids to achieve desired consistency, use to thicken fluids, follow directions on the container, 3 scoops into fluids. On April 26, 2023, at 10:53 a.m., clinical nurse supervisor (CNS)-C stated R3's Thick-it should have better instructions written for staff to follow. The licensee's Medication Management Services policy revised January 16, 2023, indicated when administration of medication is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has; -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and -communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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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 record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, 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 potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted April 25, 2023, at approximately 10:30 a.m. with maintenance (M)-F on the hazard vulnerability assessment for the	02040		

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02040	Continued From page 36 physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment and identified hazards with mitigation factors on and around the property. This deficient condition was verified by M-F during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:	02170		

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02170	Continued From page 37 (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an activity plan for three of three residents (R2, R3, R4) who received services under an 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 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: The facility currently held an Assisted Living with Dementia Care license. R2 R2's diagnoses included unspecified dementia without behavioral disturbance and other malaise	02170		

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02170	Continued From page 38 (a feeling of weakness, overall discomfort, illness, or simply not feeling well). R2's Life Enrichment Summary dated February 18, 2023, identified R2's past hobbies and interests and emotional needs, however the evaluation did not include the following: - current abilities and skills - physical abilities and limitations - adaptations necessary for the resident to participate, and - identification of activities for behavioral interventions; and -a fully completed individual activity plan. R3 R3's diagnoses included dementia without behavioral disturbances and adjustment disorder with mixed disturbance of emotions and conduct. R3's Life Enrichment Summary dated December 28, 2022, identified R3's past hobbies and interests and emotional needs, however the evaluation did not include the following: - current abilities and skills - physical abilities and limitations - adaptations necessary for the resident to participate; and -a fully completed individual activity plan. R4 R4's diagnoses included dementia without behavioral disturbances. R4's Life Enrichment Summary dated February 4, 2023, included a comprehensive activity evaluation which included all the required contents; however, R4's Life Enrichment Summary lacked an individual activity plan.	02170		

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VIRGINIA CAREFREE LIVING	421 10TH STREET SOUTH VIRGINIA, MN 55792

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02170	Continued From page 39 On April 26, 2023, at 1:16 p.m., life enrichment staff (LE)-K stated she did the evaluation form with residents however, she did not make an activity plan based off the evaluation. The licensee's ALDC Life Enrichment Programs, Activities & Outdoor Space policy revised dated August 1, 2021, indicated activities and life enrichment programs were implemented in the follow manner: -each resident would be evaluated for activities of interests using the Life Enrichment Assessment; -the facility's comprehensive assessment would additionally address the following: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitation; -adaptations necessary for the resident to participate, and -identification of activities for behavioral interventions; -an individualized actively plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs; -The nurse creating the service plan would note in the Life Enrichment service, which activities are of interest to the resident and current abilities and skills, as appropriate; -a selection of daily structured and non-structured activities must be provided and included on the resident's actively service or care plan as appropriate. Activity options based on resident evaluation may include but are not limited to: -occupation or chore related tasks; -scheduled and planned events such as entertainment or outings; -spontaneous activities for enjoyment or those that may help defuse a behavior;	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33023	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA CAREFREE LIVING	421 10TH STREET SOUTH VIRGINIA, MN 55792

(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
02170	Continued From page 40 -one-to one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; -spiritual creative, and intellectual activities; -sensory stimulation activities; -physical activities that enhance or maintain a resident's ability to ambulate or move, and -outdoor activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of four employees (ULP-I), observed during medication administration. 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	02320		

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	33023	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA CAREFREE LIVING	421 10TH STREET SOUTH VIRGINIA, MN 55792

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02320	Continued From page 41 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 unspecified dementia without behavioral disturbances. R4's Service Plan dated August 30, 2022, indicated R4 required assistance with medication administration. R4's prescriber orders dated January 25, 2023, included the following medications: -aspirin (pain reliever) 81 milligrams (mg) one tablet daily; -cetirizine (treats allergy symptoms) 10 mg one tablet daily; -ferrous sulfate (treats low iron levels) elixir five milliliter (ml) twice a day; -fiber therapy (treats constipation) 17 grams (gm) use as directed daily; -isosorbide monomer (treats heart disease) 60 mg extended release (ER) one tablet daily; -omeprazole(treats heartburn) 20 mg one capsule daily; -potassium chloride ER (supplement) one tablet daily and to put in separate cup for resident to mix independently; and -Systane eye drops (treats dry eyes) one drop in each eye four (4) times a day. R4's April Medicaiton Administration Record (MAR) did not indicate R4's ferrous sulfate or fiber therapy could be left with R4 to self adminster after set up. R4's Mediation Management Plan dated July 20,	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33023	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA CAREFREE LIVING	421 10TH STREET SOUTH VIRGINIA, MN 55792

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02320	Continued From page 42	02320		

2022, indicated R4 required medication administration services provided by the licensee.

On April 26, 2023, at 8:00 a.m., the surveyor observed ULP-I prepare R4's scheduled morning medications:
-aspirin
-cetirizine
-Ferrous Sulfate
-fiber therapy
-Isosorbide
-omeprazole
-potassium chloride ER, and
-Systane eye drops .

ULP-I poured five (5) ml of ferrous sulfate elixir into a plastic up and mixed it with juice, then scooped 17 gm of the fiber therapy power and put into a cup. ULP-I gathered all prepared medications, entered R4's room and placed the cup of juice mixed with ferrous sulfate liquid and the cup with the fiber therapy powder on the table next to R4. ULP-I administered R4's pills then exited R4's room leaving the cups with the fiber therapy and liquid ferrous sulfate on the side table for R4 to later take on her own. Immediately following R4's medication pass, ULP-I returned to the medication cart and documented in R4's MAR. R4's medications were administered. ULP-I stated R4 did not like to take her fiber therapy all at once and would mix it with water and drink both the juice mixed with ferrous sulfate throughout the morning. ULP-I confirmed in R4's EMAR did not indicate R4's fiber therapy or ferrous sulfate could be left in R4's room to self-administer at a later time.

On April 26, 2023, at 10:18 a.m., clinical nurse supervisor (CNS)-C stated R4 did not have a self medication assessment completed and further

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	33023	A. BUILDING: _____ B. WING _____	04/26/2023

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02320	Continued From page 43 stated she was unaware R4's fiber therapy and ferrous sulfate were being left with R4 to take on her own. CNS-C stated staff were expected to observe all medications being taken by the resident unless the resident was assessed and deemed competent to self administer medications and the residents care plan indicated it was ok to leave medications with the resident after set up. ULP-I's education transcript indicated ULP-I had been trained on medication administration on September 3, 2019. The licensee's Documentation of Medication Services on the MAR dated August 3, 2022, indicated staff would administer the medications according to the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided in a person-centered manner that promoted resident dignity for one of two residents (R2) who resided in the secued unit. This practice resulted in a level two violation (a	02350		

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	33023	A. BUILDING: _____ B. WING _____	04/26/2023

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02350	Continued From page 44 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included unspecified dementia without behavioral disturbance, dysphagia (difficulty swallowing) and other malaise (a feeling of weakness, overall discomfort, illness, or simply not feeling well). R2's s Service Plan dated August 16, 2022, indicated the resident required assistance with transfers, dressing and undressing, grooming, bed mobility, escorts within the building, was dependent with toileting, and eating assist. R2's Assisted Living Assessment dated March 14, 2023, indicated R2 required assistance with all transfers with gait belt, assistance with bed mobility, assistance with escorts to and from any destination either due to need for physical assist or for cognitive deficit. R2's April 1, 2023, through April 24, 2023, Service Check list indicated R2 required assistance of 1 staff to transfer with use of gait belt. On April 25, 2023, at 11:52 a.m., the surveyor observed R2 sitting in a wheelchair which was pushed up to a table in the commons area. R2 was wearing a transfer belt drinking an Ensure (nutritional supplement).	02350		

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	33023	A. BUILDING: _____ B. WING _____	04/26/2023

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02350	Continued From page 45 On April 25, 2023, at 3:42 p.m., clinical nurse supervisor (CNS)-C stated the transfer belt used to assist R2 into the wheelchair was to have been removed once R2 was positioned in the wheelchair. The Minnesota Bill of Rights for Assisted Living Residents authenticated on March 18, 2023, by R2's legal representative noted residents have the right to be treated with courtesy and respect. In addition, residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		

MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: *04/25/23*
Time: 10:00:18
Report: 1032231073

Food and Beverage Establishment Inspection Report

Location:
Virginia Carefree Living, LLC
421 10th Steet South
Virginia, MN55792
St. Louis County, 69

Establishment Info:
ID #: 0033296
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Virginia Carefree Living, LLC

Phone #: 2182488626
ID #: 47038

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.

3-800 Highly Susceptible Populations

3-801.11B ***** Priority 1 *****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

UNPASTEURIZED EGGS ARE ONLY ALLOWED TO BE USED FOR A SINGLE SERVING TO A SINGLE GUEST. BATCH MADE SCRAMBLED EGGS MUST BE FROM PASTEURIZED EGGS. DISCONTINUE USING UNPASTEURIZED EGGS FOR BATCHES OF SCRAMBLED EGGS.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-602.11A ***** Priority 1 *****

MN Rule 4626.0845A Clean and sanitize food-contact surfaces of equipment and utensils: 1. before each use with a different type of raw animal food; 2. each time there is a change from working with raw foods to working with ready-to-eat foods; 3. between uses with raw fruits and vegetables and TCS foods; 4. before using or storing a food temperature measuring device; 5. at any time during the operation when contamination may have occurred.

ICE BIN NEEDS TO BE DRAINED AND CLEANED, MOLD GROWING INSIDE

Comply By: 04/28/23

3-200B Food Characteristics:Receiving: temperature, condition

3-202.15 ***** Priority 2 *****

MN Rule 4626.0190 Food packages must be in good condition and must protect the food from adulteration and potential contaminants.

5 DENTED FOOD CANS FOUND, APPLE SAUCE, APPLE PIE FILLING, PEARS, WERE REMOVED.

Corrected on Site

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS AT HANDWASHING STATION

Corrected on Site

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

HOT DOG BUNS FOUND ON FLOOR OF WALK-IN COOLER

Corrected on Site

6-200 Physical Facility Design and Construction

6-201.17A

MN Rule 4626.1365A Install or replace wall and ceiling attachments including light fixtures, mechanical room ventilation system components, vent covers, wall mounted fans, decorative items and other attachments to be easily cleanable.

CEILING TILE MISSING IN THE KITCHEN, REPLACE MISSING CEILING TILE

Comply By: 04/28/23

6-300 Physical Facility Numbers and Capacities

6-303.11A

MN Rule 4626.1470A Provide at least 10 foot candles (108 LUX) of light intensity at a distance of 30 inches from the floor in the walk-in refrigeration units, dry food storage areas, and in other areas during periods of cleaning.

WALK-IN FREEZER LIGHT WAS VERY LOW, CHANGE LIGHT BULB AND REMOVE BOXES AROUND THE LIGHT.

Comply By: 04/28/23

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: HAM
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

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

Process/Item: Upright Cooler 2
Temperature: 41 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler 2
Temperature: 41 Degrees Fahrenheit - Location: BUTTER
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 35 Degrees Fahrenheit - Location: BUTTER
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 35 Degrees Fahrenheit - Location: PEACHES
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 35 Degrees Fahrenheit - Location: PASTA SAUCE
Violation Issued: No

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

Process/Item: Walk-In Freezer
Temperature: Degrees Fahrenheit - Location: FROZEN
Violation Issued: No

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

REPORT REVIEWED WITH KITCHEN MANAGER KATHLEEN. POTENTIAL HAZARDS IN DAY-TO-DAY OPERATION WERE DISCUSSED, INCLUDING EMPLOYEE ILLNESS, EXCLUDING/RESTRICTING EMPLOYEES EXPERIENCING ILLNESS SYMPTOMS, RECORDING EMPLOYEE ILLNESS SYMPTOMS.

DISCUSSED CREATING CLEANING SCHEDULE FOR THE ICE MACHINE TO PREVENT MOLD BUILD UP.

DISCUSSED USE OF PASTEURIZED EGGS. SINGLE SERVING OF SCRAMBLED EGGS FOR A SINGLE GUEST IS OKAY, BUT SCRAMBLED EGGS FOR MORE THAN ONE PERSON MUST BE PASTEURIZED EGGS.

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 MDH inspection report number 1032231073 of 04/25/23.

Certified Food Protection Manager: KATHLEEN M ECK

Certification Number: FM115807 Expires: 01/31/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

KATHLEEN M ECK
KITCHEN MANAGER

Signed: _____

Ben Kubes
Environmental Health Specialist
Duluth
ben.kubes@state.mn.us

Report #: 1032231073

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH

11 E Superior Street
Duluth

No. of RF/PHI Categories Out	4	Date	04/25/23
No. of Repeat RF/PHI Categories Out	0	Time In	10:00:18
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Virginia Carefree Living, LLC	421 10th Steet South	Virginia, MN	55792	2182488626

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0033296	Virginia Carefree Living, LLC	Full		M

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 04/25/23

Inspector (Signature)