Electronically Delivered

November 8, 2024

Licensee
First Light Residential Care LLC
3537 Lee Avenue North
Crystal, MN 55422

RE: Project Number(s) SL37693015

Dear Licensee:

On October 9, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 17, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 16, 2024

Licensee
First Light Residential Care LLC
3537 Lee Avenue North
Crystal, MN 55422

RE: Project Number(s) SL37693015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37693	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST LIGHT RESIDENTIAL CARE L	3537 LEE AVENUE NORTH CRYSTAL, MN 55422

(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: SL37693015-0 On July 15, 2024, through July 17th, 2024, 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 4 residents, 3 of whom were receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 16, 2024, issued for SL37693015-0, tag identification 0820. On July 19, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G.	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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the employee record contained training and competency evaluations for one of one unlicensed personnel (ULP)-C who performed delegated tasks. 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	0 650		

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0 650	Continued From page 2 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C had a hire date of December 21, 2023. ULP-C's record lacked documentation of training in medication, exercise, treatment reminders and preparing medications for unplanned times away. ULP-C's record also lacked documentation that competency testing in preparing medications for unplanned times away had been completed. On July 16, 2024, at 8:45 a.m., the surveyor observed ULP-C assist R1 with medication administration. On July 16, 2024, at 2:45 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. CNS/LALD-A stated she had provided all training and competency testing regarding medications with the ULP in person, at the time of hire, but she had not been documenting the training or testing. The licensee's 2.14 Staff Competency policy, dated August 1, 2021, indicated staff would be trained and tested in the above areas, and documentation of completion would be kept in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 3 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to 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, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 4 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's undated Assisted Living Emergency Preparedness Manual lacked the following required content: - EP policies/procedures review/updated annually; -transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; -develop policy and procedures to address: -provision of subsistence needs for staff and residents to include food and water -use of volunteers, including the process/role for integration; -role of the licensee under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - Communication plan must include all the following: - contact information for federal, state, tribal, local emergency preparedness staff'; -EP testing requirements including an annual full-scale exercise or individual facility-based functional exercise. On July 17, 2024, at 9:13 a.m., the licensee's emergency preparedness plan was reviewed with clinical nursing supervisor/licensed assisted living director (CNS/LALD)-A. CNS/LALD-A stated she was not aware of the annual full-scale exercise or individual facility-based functional exercise requirement and thought the licensee's plan	0 680		

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0 680	Continued From page 5 contained all the required content. The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated a full-scale functional exercise would be conducted at least annually and the emergency preparedness plan would be reviewed annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 (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	0 810		

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0 810	Continued From page 6 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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to provide required employee training on fire safety and evacuation as required. This had the potential 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 16, 2024, at 2:00 p.m., the owner, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.	0 810		

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0 810	Continued From page 7 FIRE SAFETY AND EVACUATION PLAN The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The fire safety and evacuation plan was a third-party consultant provided plan, and it was not updated relative to the facility's building layout and environmental risks. The fire safety and evacuation plan included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP did not identify specific fire protection actions for residents, as evidenced by the lack of instructions in the FSEP. During the interview on July 16, 2024, at 2:30 p.m., CNS/LALD-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on July 16, 2024, at 2:30 p.m., CNS/LALD-A stated that the licensee provided annual fire safety training provided by third party, but the provided training did not include any facility-specific evacuation procedure contents. O/CNS/LALD-A confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required	0 810		

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0 810	Continued From page 8 by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	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 ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied residents in bedrooms 4 on the main level. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was	0 820	This immediate correction order identified on July 16, 2024, has had the immediacy lifted as of July 19, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 9 issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 16, 2024, at 1:00 p.m., survey staff toured the facility with the owner, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom 4 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 15 inches in height and 30 inches in width, with a total openable area of 450 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to CNS/LALD-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. CNS/LALD-A verbally confirmed the findings. On July 16, 2024, at 2:00 p.m., during the interview, survey staff explained to CNS/LALD-A that an immediate correction order was issued for the above finding. CNS/LALD-A acknowledged	0 820		

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0 820	Continued From page 10 the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to submit renovation project plans to Minnesota Department of Health (MDH) Engineering for review and approval. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 16, 2024, at 1:00 p.m., survey staff toured the facility with the owner, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A and unlicensed personnel (ULP)-E. During the facility tour, survey staff observed the following:	0 830		

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0 830	Continued From page 11 It was observed that the facility was under ongoing construction, which consisted of window replacement in three resident rooms on the main level. During the facility tour, a window was observed to have been removed, and there was a large hole in the wall in the resident sleeping room 2. During the interview on July 16, 2024, at 2:00 p.m., the survey staff asked CNS/LALD-A if the construction work was done with MDH review and prior approval or with an approved construction permit from the local Building Official. CNS/LALD-A started they did no not have an approved construction permit from the local Building Official. During the same interview, survey staff explained to CNS/LALD-A that renovation or physical changes altering the use of occupancy of a licensed assisted living facility must be submitted to MDH Engineering for review and approval. CNS/LALD-A stated that the facility was not aware of the MDH approval requirement and verified this deficient condition. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 830		
01850 SS=D	144G.71 Subd. 16 Written or electronic prescription When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the resident's record. This MN Requirement is not met as evidenced	01850		

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FIRST LIGHT RESIDENTIAL CARE L	3537 LEE AVENUE NORTH CRYSTAL, MN 55422

(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
01850	Continued From page 12 by: Based on interview and record review, the licensee failed to ensure a written prescription order was recorded in the resident's record for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnosis included Type 2 diabetes and cognitive developmental delay. R1's service plan dated April 20, 2024, indicated the resident received services to include medication management. An after visit summary/signed provider's order, dated May 22, 2024, indicated R1's insulin glargine (a long-acting insulin) was to increase to 22 units daily. R1's medication administration record from June 1, 2024, through July 16, 2024, indicated R1 received Basaglar Kwikpen (a brand name injection pen for insulin glargine) 20 units daily. On July 16, 2024, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer 20 units of the Basaglar Kwikpen to R1. On July 16, 2024, at 10:30 a.m., owner and	01850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37693	A. BUILDING: _____ B. WING _____	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST LIGHT RESIDENTIAL CARE L	3537 LEE AVENUE NORTH CRYSTAL, MN 55422

(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
01850	Continued From page 13 clinical nursing supervisor/licensed assisted living director (CNS/LALD)-A stated she had accompanied R1 to the appointment with the provider on May 22, 2024, but the increase in insulin glargine was not discussed and was missed. The licensee's Medication Orders policy, dated August 1, 2021, indicated all medications would be administered as prescribed by the authorized prescriber. The policy further indicated when a written or electronic prescription was received, it would be placed in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01850		
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 medications were stored according to manufacturer's instructions. 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	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37693	A. BUILDING: _____ B. WING _____	07/17/2024

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01880	Continued From page 14 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 July 15, 2024, at 1:50 p.m., in the presence of owner and clinical nurse supervisor/licensed assisted living director (CNS/LALD)-A, the surveyor observed the contents of the licensee's medication refrigerator, which included two unopened Ozempic (semaglutide, single use insulin pen used to improve blood sugar levels) and a box containing 5 unopened Lantus (insulin glargine, a long-acting insulin) pens kept in a tray on one of the shelves. The box was observed to be wet and there was a small amount of water in the tray. The refrigerator lacked a thermometer to record temperature. CNS/LALD-A stated there should be a thermometer in the refrigerator and she was not sure why it was not there. The manufacturer's prescribing information for the use of Ozempic pens, dated October 2023, indicated unopened medication should be refrigerated at 36-46 degrees Fahrenheit (F). The manufacturer's prescribing information for the use of Lantus insulin pens, revised June 2023, indicated unopened medication should be refrigerated at 36-46 degrees F. The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated medications requiring refrigeration would be stored in an enclosed container, and the temperature would be maintained at 35-40 degrees F.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37693	A. BUILDING: _____ B. WING _____	07/17/2024

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FIRST LIGHT RESIDENTIAL CARE L	3537 LEE AVENUE NORTH CRYSTAL, MN 55422

(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
01880	Continued From page 15 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 ensure time sensitive medications were labeled with the date opened for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnosis included Type 2 diabetes and cognitive developmental delay. R1's service plan dated April 20, 2024, indicated the resident received services to include medication management.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37693	A. BUILDING: _____ B. WING _____	07/17/2024

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01890	Continued From page 16 On July 16, 2024, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer 20 units of the Basaglar Kwikpen (a brand name injection pen for insulin glargine) to R1. The time sensitive medication lacked an opened date label. On July 16, 2024, at 9:04 a.m., ULP-C stated she normally puts an opened date on the medication, but "forgot." -Owner and clinical nursing supervisor/licensed assisted living director (CNS/LALD)-A stated the medication should have been dated when it was opened, and she would post a reminder for staff to be sure to date time sensitive medications. The manufacturer's prescribing information for the use of Basaglar Kwikpen, revised November 2023, indicated the medication should be discarded 28 days after first use. The licensee's Storage/Control of Medications policy, dated August 1, 2021, indicated the licensed nurse is responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *07/15/24*
Time: 11:00:00
Report: 1051241052

Food and Beverage Establishment Inspection Report

Location:
First Light Residential Care L
3537 Lee Avenue North
Crystal, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0038129
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9523141216
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: AMBIENT
Violation Issued: No

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

MET WITH NURSE EVALUATOR, TAMMY CARLSON.
DISCUSSED THE FOLLOWING WITH THE OWNER, SHAMSO:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
CERTIFIED FOOD MANAGER PROTECTION RENEWAL (APPLICATION SENT)

THE KITCHEN HAS AN NSF 184 DISHMACHINE, LAMINATE COUNTERTOPS, TILE FLOORS, AND A SMOOTH TEXTURE CEILING.

Type: Full
Date: *07/15/24*
Time: 11:00:00
Report: 1051241052
First Light Residential Care L

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 Minnesota Department of Health inspection report number 1051241052 of 07/15/24.

Certified Food Protection Manager: Shamso M. Hassan

Certification Number: FM111609 Expires: 08/10/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Shamso M. Hassan
Owner

Signed: _____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us