DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 3, 2023

Licensee
Babbitt Carefree Living
1 Central Boulevard
Babbitt, MN 55706

RE: Project Number(s) SL29103015

Dear Licensee:

On March 16, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the February 2, 2023, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Electronically Delivered

February 23, 2023

Licensee
Babbitt Carefree Living
1 Central Boulevard
Babbitt, MN 55706

RE: Project Number(s) SL29103015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 2, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email 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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29103	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BABBITT CAREFREE LIVING	1 CENTRAL BOULEVARD BABBITT, MN 55706

(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: SL29103015 On January 30, 2023, through February 2, 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 31 active residents receiving services under the Assisted Living with Dementia Care license. Immediate correction orders were identified on February 1, 2023, issued for SL29103015, tag identification 1750 and 1950. On February 3, 2023, the immediacy of correction orders 1750 and 1950 was removed, however, non-compliance remained at a scope and level of H.	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	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the 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 January 30, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 2 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 develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 3 During the entrance conference on January 30, 2023, at 10:48 p.m., the evaluator requested the licensee's EPP, which was provided to and later reviewed by the evaluator. The licensee's emergency plan lacked the following content and/or policies and procedures to address: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee to identify at risk populations; - subsistence needs for staff and residents during an emergency to include (medical supplies, pharmacy supplies, sewer and waste disposal); - shelter in place to meet the needs of the residents; - the facility's role in providing care and treatment at alternative sites; - missing persons policy that was reviewed quarterly; - EP testing/annual requirements; and -written arrangements with other facilities or providers. In addition, the licensee lacked a communication plan that included: - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; and - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies. On February 2, 2023, at 1:26 p.m., the evaluator reviewed the licensee's EPP with administrator coordinator (AC)-D. AC-D stated she was responsible for developing and maintaining the	0 680		

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0 680	Continued From page 4 licensee's EPP. AC-D verified the licensee's EPP was not fully developed and had blank templates that had not been fully completed. The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place a general emergency preparedness plan, that was alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730		

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0 730	Continued From page 5 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of services were maintained 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 pattern scope (when more than a limited number of residents are affected, more	0 730		

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0 730	Continued From page 6 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included dementia, diabetes, and hypertension (high blood pressure). R2's service plan dated December 5, 2022, indicated services included medication administration, bathing, toileting, dressing, heavy cleaning/apartment inspection on every Tuesday, light cleaning every day, and laundry two (2) loads per week. R2's January 2023, Service Checkoff List indicated the unlicensed personnel (ULP) documented the services as follows: -heavy cleaning/apartment inspection three (3) out of four (4) opportunities. R3 R3's diagnoses included dementia, degenerative joint disease, lower back pain, and hypertension (high blood pressure). R3's service plan dated December 12, 2022, indicated services included medication administration, bathing, dressing, grooming, safety checks, heavy cleaning/apartment inspection on every Friday, light cleaning every day, and laundry two (2) loads per week. R3's January 2023, Service Checkoff List indicated ULP documented the services as follows: -heavy cleaning/apartment inspection three (3) out of five (5) opportunities.	0 730		

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0 730	Continued From page 7 R4 R4's service plan dated December 1, 2022, indicated services included medication administration, assistance with showers one (1) time a week, safety check once per shift, heavy cleaning/apartment inspection on every Monday, light cleaning every day, and laundry two (2) loads per week. R4's Service Checkoff List indicated the unlicensed personnel (ULP) documented the services as follows: -safety checks documented zero (0) out of 93 opportunities; and -heavy cleaning/apartment inspection one (1) out of five (5) opportunities. On January 31, 2023, at 11:50 a.m., H-K stated she completed the weekly heavy cleaning of all resident apartments. H-K stated she sometimes forgets to document housekeeping services provided in the resident's electronic medical records. On February 1, 2023, at 12:44 p.m., director of nursing/registered nurse (DON/RN)-C confirmed R2, R3 and R4's services were not documented as indication above. The licensee's Service Check-Off List Documentation policy dated August 1, 2022 indicated documentation on the service check-off list verified that assigned services were understood and have been done. The documentation on the service check-off list would be reviewed prior to filing in the resident's chart. No further information was provided.	0 730		

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0 730	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition 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). Findings include: On a facility tour on January 31, 2023, at	0 800		

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0 800	Continued From page 9 approximately 11:00 a.m. with resident assisted living director (RALD)-A and maintenance (M)-G, it was observed that a metal trim piece on the bottom of the marked exit door next to resident room 117 was partially detached and rubbing the exterior landing. At the time of the facility tour, documentation was not available of the required commercial kitchen hood and duct cleaning records. On the same tour it was observed a toilet grab bar was not secured to the wall in the restroom across from resident room 106. It was also observed that a large commercial mixer was stored in the exit corridor outside of the commercial kitchen. Marked exit routes are required to be kept clear of objects that prevent the full and immediate use of the exit. An extension cord was observed fastened to the exterior surface of the wall and used as permanent wiring for an electric lift chair in the dementia care common living room. It was observed that the exterior exit path leading through the gated area from the marked exterior exit door in the dining room of the dementia care unit and the marked exterior exit door next to resident room 217 were not maintained clear of ice and snow from the marked exit doors to the public way. Keeping this exterior exit path and the exterior door landings clear of ice and snow helps provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. At the time of the facility tour it was observed that the numerical keypad switch to open the secured	0 800		

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0 800	Continued From page 10 marked exit door from the dining room of the dementia care unit was not working as designed and installed. These deficient conditions were visually verified by RALD-A and M-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

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BABBITT CAREFREE LIVING	1 CENTRAL BOULEVARD BABBITT, MN 55706

(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
0 810	Continued From page 11 (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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. 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). A record review and interview were conducted on January 31, 2023, at approximately 10:15 a.m. of documents provided by resident assisted living director (RALD)-A, director of patient care compliance (RN)-B, director of nursing/ registered nurse (DON/RN)-C and maintenance (M)-G on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include:	0 810		

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0 810	Continued From page 12 Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows: Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents in the event of a fire or similar emergency. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees in regard to resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. 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. 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. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and at least once every other month as required. All deficiencies were verified by RALD-A, RN-B, DON/RN-C and M-G during the interview at approximately 10:30 a.m.	0 810		

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0 810	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	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 all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). Findings include:	0 820		

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0 820	Continued From page 14 On a facility tour on January 31, 2023, at approximately 11:30 a.m. with resident assisted living director (RALD)-A and maintenance (M)-G it was observed that a portable space heater was present in resident room 205 within this dementia care facility. Space heaters are not allowed in sleeping rooms of dementia care units, they are only allowed in non-sleeping and employee areas. This deficient condition was visually verified by RALD-A and maintenance M-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days.	0 820		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an	0 930		

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0 930	Continued From page 15 unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of three residents (R2, R3, R4). This had the potential to affect all 31 residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses included dementia, diabetes, and hypertension (high blood pressure). R2's service plan dated December 5, 2022, indicated services included medication administration, bathing, toileting, dressing, heavy cleaning/apartment inspection on every Tuesday, light cleaning every day, and laundry two (2) loads per week. R3 R3's diagnoses included dementia, degenerative joint disease, lower back pain, and hypertension (high blood pressure). R3's service plan dated December 12, 2022, indicated services included medication administration, bathing, dressing, grooming,	0 930		

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0 930	Continued From page 16 safety checks, heavy cleaning/apartment inspection on every Friday, light cleaning every day, and laundry two (2) loads per week. R4 R4's diagnoses included diabetes and bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs). R4's service plan dated December 1, 2022, indicated services included medication administration, assistance with showers one (1) time a week, safety check once per shift, heavy cleaning/apartment inspection on every Monday, light cleaning every day, and laundry two (2) loads per week. R2, R3 and R4's signed assisted living contracts dated January 26, 2023, September 7, 2022, and June 2, 2022 respectively, lacked the following content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer. On January 31, 2023, at 1:09 p.m., director of nursing/registered nurse (DON/RN)-C confirmed R2, R3 and R4's assisted living contract and all other resident's assisted living contracts did not contain the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer. No further information was provided.	0 930		

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0 930	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
01370 SS=E	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; (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	01370		

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01370	Continued From page 18 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 two of two unlicensed personnel (ULP-F, ULP-H) 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-F ULP-F was hired on November 17, 2021, to provide direct care under the assisted living license. On January 30, 2023, during the survey ULP-F was observed to provide direct care services to several residents. ULP-F's employee record lacked evidence ULP-F had received the following training: -basic nutrition, meal preparation, food safety, and assistance with eating; and	01370		

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01370	Continued From page 19 -preparation of modified diets as ordered by a licensed health professional. ULP-H ULP-H was hired on October 4, 2022, to provide direct care under the assisted living license. On January 31, 2023, at 2:52 p.m., ULP-H was observed administering R5's scheduled 2:00 p.m., medications. ULP-H's employee record lacked evidence ULP-H had received the following training: -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -awareness of commonly used health technology equipment and assistive devices; and -recognizing physical, emotional, cognitive, and developmental needs of the client. On February 1, 2023, at 1:00 p.m., administrator coordinator (AC)-D confirmed ULP-F and ULP-H had not completed the training as indicated above. The licensee's Training and Competency Evaluation of Unlicensed Staff policy last reviewed January 23, 2019, indicated the following are required training topics for unlicensed personnel: -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -awareness of commonly used health technology equipment and assistive devices; and -recognizing physical, emotional, cognitive, and developmental needs of the client.	01370		

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01370	Continued From page 20 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
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 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	01500		

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01500	Continued From page 21 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: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment, including required content, for one of one employee (unlicensed personnel (ULP)-F). 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	01500		

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01500	Continued From page 22 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: ULP-F was hired on November 17, 2021, to provide direct care services under the licensee's assisted living with dementia care license. ULP-F's employee records lacked annual training on the following required topic: -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 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -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. On February 1, 2023, at 1:00 p.m., administrator coordinator (AC)-D confirmed ULP-F had not completed the required annual training as listed above. The licensee's Training and Competency Evaluation of Unlicensed Staff dated January 23, 2019, indicated all staff that perform direct home care services must complete at least eight to	01500		

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01500	Continued From page 23 twelve hours of annual training for each 12 months of employment. The annual training must include: -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 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -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		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	01540		

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01540	Continued From page 24 and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three employees (unlicensed personnel (ULP)-F, ULP-H) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-F ULP-F was hired on November 17, 2021, to provide direct care services under the licensee's assisted living with dementia care license. On January 30, 2023, during the survey ULP-F was observed to provide direct care services to several residents. ULP-F's employee record indicated ULP-F had	01540		

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01540	Continued From page 25 completed seven (7) hours of dementia training. ULP-H ULP-H was hired on October 4, 2022, to provide direct care under the assisted living license. On January 31, 2023, at 2:52 p.m., ULP-H was observed administering R5's scheduled 2:00 p.m., medications. ULP-H's employee record indicated ULP-H had completed 7.25 hours of dementia training. On February 1, 2023, at 1:50 p.m., administrator coordinator (AC)-D confirmed ULP-F had completed seven (7) hours of dementia training and ULP-H had completed 7.25 hours of dementia training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 26 (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans included the required content 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). R2 R2's diagnoses included dementia, diabetes, and hypertension (high blood pressure). R2's service plan dated December 5, 2022, indicated services included medication administration, bathing, toileting, dressing, heavy	01650		

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cleaning/apartment inspection on every Tuesday, light cleaning every day, and laundry two (2) loads per week.

R3
R3's diagnoses included dementia, degenerative joint disease, lower back pain, and hypertension (high blood pressure).

R3's service plan dated December 12, 2022, indicated services included medication administration, bathing, dressing, grooming, safety checks, heavy cleaning/apartment inspection on every Friday, light cleaning every day, and laundry two (2) loads per week. R3's service plan did not include a statement of treatment services provided to include assistance with compression stockings.

R3's prescriber's orders dated January 11, 2023, included anti-embolism stockings to wear as directed daily.

R3's Medication Administration Record (MAR) dated December 1, 2022, through January 11, 2023, indicated R3 received assistance with compression stockings twice a day.

R4
R4's diagnoses included diabetes and bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs).

R4's service plan dated December 1, 2022, indicated services included medication administration, assistance with showers one (1) time a week, safety check once per shift, heavy cleaning/apartment inspection on every Monday, light cleaning every day, and laundry two (2)

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01650	Continued From page 28 loads per week. R2, R3 and R4's service plans did not include the following required content: -the method of monitoring assessments of the resident; and -the method of monitoring staff providing services. On January 31, 2023, at 1:09 p.m., registered nurse (RN)-B confirmed the licensee's service plan was a template and used for all residents. On February 1, 2023, at 12:44 p.m., director of nursing/registered nurse (DON/RN)-C confirmed R2, R3 and R4's service plans were not documented as indicated above. The licensee's Contents of Service Plans policy reviewed August 3, 2022, indicated the service plan would include the following content: -the method of monitoring assessments of the resident; and -the method of monitoring staff providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01750 SS=H	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications,	01750		

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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 records; and
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, for two of three unlicensed personnel (ULP-F, ULP-I) demonstrated competency for administering medications. This had the potential to affect all 31 residents receiving assisted living services.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

This resulted in an immediate correction order on February 1, 2023.

The findings include:

ULP-F
ULP-F was hired on November 17, 2021, to provide direct care services under the licensee's assisted living with dementia care license.

ULP-F's training record lacked evidence ULP-F

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01750	Continued From page 30 had been trained by a registered nurse (RN) and demonstrated competency in medication administration. R4's December 2022, medication administration record (MAR) indicated ULP-F administered R4's morning medications on December 1, 4, 5, 8, 9, 10, 12, 13,15,17, 18, 19,20, 21, 22, 23, 25, and 26, 2022. R4's January 2023, MAR indicated ULP-F administered R4's morning medications on January 2, 5, 6, 7, 10, 11, 12, 13, 14, 15, 18, 19, 20, 22, 23, 25, 26, 27, and 30, 2023. ULP-F's Medication Administration Competency Determination forum dated December 23, 2021, indicated licensed practical nurse (LPN)-J completed the training on medication administration and performed the competency training for medication administration. ULP-I ULP-I was hired on July 19, 2021, to provide direct care services under the licensee's assisted living with dementia care license. ULP-I's training record lacked evidence ULP-I had been trained by an RN and demonstrated competency in medication administration. R4's January 2023 MAR, indicated ULP-I administered the following medications: -January 20, 2023, at 4:03 a.m. acetaminophen (pain relief) 325 mg (milligrams) two tablets. -January 24, 2023, at 7:00 a.m. metformin 1000 mg one tablet; fluticasone (allergies), instill two (2) sprays nasally daily; and lithium (treat bipolar disorder) 600 mg.	01750		

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01750	Continued From page 31 ULP-I's Medication Administration Competency Determination forum dated March 23, 2022, indicated LPN-J completed the training on medication administration and performed the competency training for medication administration. On February 1, 2023, at 10:35 a.m. LPN-J stated she had completed the medication administration training and competency evaluation for ULP-F and ULP-I. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated August 3, 2022, indicated prior to providing home care services to a resident, unlicensed personnel must satisfactorily complete a written, oral, or practical skills test for administering medications and treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by review by evaluation supervisor on February 3, 2023, however noncompliance remains at a scope and level of level three, pattern (H).	01750		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written	01790		

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information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before

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the medications are given to the resident or the designated representative;
(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-F) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This had the potential to affect all 31 residents.

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

The findings include:

During the entrance conference on January 30, 2023, at 10:30 a.m., director of nursing/registered nurse (DON/RN)-C indicated the licensee provided medication management services to thirty-one (31) residents and the ULP would prepare and send medications with the residents

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01790	Continued From page 34 for unplanned times away. ULP-F was hired on November 17, 2021, to provide direct care services under the licensee's assisted living with dementia care license. R4's medication administration record (MAR) for January 2023, indicated ULP-F administered R4's medications on January 2, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 25, 26, and 27, 2023. ULP-F's employee record indicated on December 23, 2021, licensed practical nurse (LPN)-J completed training and competency testing to prepare and give medications for residents having unplanned time away. ULP-F's employee records lacked evidence to indicate ULP-F had been trained and demonstrated competency to prepare and provide medications to residents for unplanned times away from home by an RN. On February 1, 2023, at 10:35 a.m., LPN-J stated she had completed the training and competency testing to prepare and give medications for residents having unplanned time away for ULP-F. The licensee's Medication for a Client Who Will Be Away From Home When Medications Are Scheduled reviewed August 3, 2022, indicated the RN may delegate this task to unlicensed staff if: the RN has trained and competency tested the unlicensed staff on procedures to follow when giving medications to clients who will be away from home when medications are scheduled. No further information was provided.	01790		

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01790	Continued From page 35 TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
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 date for one of two residents (R5) observed during medication administration. Additionally, the licensee failed to ensure expired medications were not available for use. 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: NOT DATED WHEN OPENED On January 30, 2023, at 12:30 p.m., during the tour of the memory care unit, with administrator	01890		

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coordinator (AC)-D, the evaluator observed an opened bottle of R5's Timolol Maleate eye drops, in the medication cart. R5's bottle of Timolol Maleate eye drop was not dated when opened or have an expiration date. Unlicensed personnel (ULP)-E confirmed R5's Timolol Maleate eye drop was not dated when opened and did not include an expiration date.

On February 1, 2023, at 12:44 p.m., director of nursing/registered nurse (DON/RN)-C stated staff who opened eye drops should write on the bottle, the date the eye drop was first opened to ensure the eye drop was not used passed the recommended date of use.

The manufacturer's instructions for Timolol eye drop dated January 2020, indicated to use within 28 days after opening, then discard bottle.

EXPIRD MEDICATIONS

On January 30, 2023, at 12:30 p.m., the evaluator observed the following expired medications in the medication cart on the memory care unit:
-two (2) tubes of denture cream that expired March 2021; and
-one (1) tube of Bentley Psoriasis Control Cream that expired September 2021.

On January 30, 2023, at approximately 12:30 p.m., ULP-E stated the nurse checks the medication cart, but not sure how often.

The licensee's 144A.4972 Storage of Medications policy dated May 24, 2023, indicated the following:
-all prescription medications stored outside of the client's private living space must be in a securely

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01890	Continued From page 37 locked and in a substantially constructed compartment according to manufacturer's directions, to which only authorized personnel have access; and -insulin storage, refer to guidelines for insulin storage. Insulin must be stored per manufacturer guidelines. Unopened insulin that is refrigerated, must be stored between 36-46 Degrees F. This may be logged daily on a flow sheet or may be monitored on each shift and any temperatures outside of this range are to be reported to nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

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01910	Continued From page 38 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge. 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 was admitted for services on November 22, 2022, and was discharged on December 27, 2022. R1's diagnoses include vascular dementia (problems with the blood supply to the brain). R1's service plan dated November 22, 2022, indicated R1 received medication management services which included medication administration. R1's discharge summary indicated R1 was transferred to another facility on December 27, 2022. R1's December 2022, Medication Administration Record (MAR) indicated R1 received the	01910		

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following scheduled medications:
-Eliquis 2.5 mg (milligrams) twice a day (treat chronic atrial fibrillation);
-ferrous sulfate one tablet daily (treat iron deficiency anemia);
-furosemide 20 mg daily (treat heart failure);
-glucos/chond tab 750-600 one tablet twice a day (treat chronic kidney disease); and
-lisinopril 10 mg two (2) tablets daily (treat high blood pressure).

R1's prescriber's orders dated November 22, 2022, included all the above noted medications.

R1's Record of the Inventory and Destruction of Controlled and Uncontrolled Substances dated December 28, 2022, included the name, strength, prescription number, quantity, to whom the medications were given, date of disposition and names of staff and other individuals involved in the disposition for the following medications:
-Eliquis 2.5 mg;
-furosemide 20 mg;
-glucos/chond tab 750-600; and
-lisinopril 10 mg.

R1's Record of the Inventory and Destruction of Controlled and Uncontrolled Substances dated December 28, 2022, did not included the name, strength, prescription number, quantity, to whom the medications were given, date of disposition and names of staff and other individuals involved in the disposition for the following medications:
-ferrous sulfate.

On February 1, 2023, at 12:44 p.m., director of nursing/registered nurse (DON/RN)-C stated R1's Record of the Inventory and Destruction of Controlled and Uncontrolled Substances dated December 28, 2022, did not include the name,

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01910	Continued From page 40 strength, prescription number, quantity, to whom the medications were given, date of disposition for ferrous sulfate. The licensee's Disposition or Disposal of Medication policy reviewed May 10, 2022, indicated using the form Record of the Inventory and Destruction of Controlled and Uncontrolled Substance, staff will document in the client's record the disposition of the medication including: the medications name, strength, prescription number (as applicable), quantity, method of disposition/to whom the medications were given, date of disposition and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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01940	Continued From page 41 (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include a written statement of the treatment or therapy services to be provided on the service plan for one of two residents (R3). In addition, the licensee failed to develop a treatment management plan to include all required content for one of two residents (R4) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 30,	01940		

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01940	Continued From page 42 2023, at 10:30 a.m., director of nursing/registered nurse (DON/RN)-C confirmed the licensee provided treatment and therapy services to residents. R3 R3's service plan dated December 12, 2022, did not indicate R3 received treatment or therapy services. R3's prescriber's orders dated January 11, 2023, included anti-embolism stockings to wear as directed daily. R3's Medication Administration Record (MAR) dated December 1, 2022, through January 11, 2023, indicated R3 received assistance with compression stockings twice a day. R3's Treatment and Therapy Management Plan dated January 31, 2022, indicated R3 received treatments/therapy services to include compression stockings; however, R3's treatment plan lacked a written statement of treatment services provided on R3's service plan. R4 R4's service plan dated December 1, 2022, indicated R4 received treatment management services. R4's prescriber's orders dated January 22, 2023, included blood glucose monitor twice a day. R4's January 2023, medication administration record indicated unlicensed personnel (ULP) performed blood glucose monitoring twice a day. R4's Treatment Management Plan dated January 30, 2023, lacked evidence the RN developed a	01940		

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01940	Continued From page 43 treatment management plan to include the required content for performing blood glucose monitoring: - a statement of the type of services that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On January 31, 2023, at 1:38 p.m., DON/RN-C and RN-B confirmed R3's Treatment Management Plan did not include a written statement of treatments R3 received on R3's service plan as required. On February 1, 2023, at 12:44 p.m., DON/RN-C confirmed R4's Treatment Management Plan did not include Blood glucose monitoring. The licensee's Treatment and Therapy Management Services policy dated August 1, 2021, each resident receiving prescribed treatments or therapy services, the licensee must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The licensee must also develop and maintain a current individualized treatment and therapy	01940		

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01940	Continued From page 44 management record for each resident which must contain at least the following: -Statement of the type of services that will be provided; -Documentation of specific resident instructions relating to the treatments or therapy administration; -Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; -Any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=H	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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01950	Continued From page 45 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 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating the nursing task of blood glucose and oxygen saturation monitoring, unlicensed personnel (ULP) demonstrated competency to perform the tasks or procedure to the registered nurse (RN) for two of three employees ULP-F and ULP-I. This had the potential to affect all 31 residents receiving assisted living services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). This resulted in an immediate correction order on February 1, 2023.	01950		

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01950	Continued From page 46 The findings include: ULP-F ULP-F was hired on November 17, 2021, to provide direct care services under the licensee's assisted living with dementia care license. ULP-F's training record lacked evidence ULP-F had been trained by a registered nurse (RN) and demonstrated competency in medication administration. ULP-F R4's December 2022, Medication Administration Record (MAR) indicated ULP-F performed the following treatments: -R4's Blood glucose monitoring on December 10 and 18, 2022; and -R4's Covid-19 symptom screening, including oxygen saturation monitoring on December 1, 4, 5, 7, 8, 9, 10, 12, 13, 15, 17, 18, 19, 20, 21, 22, 23, 25, 28, and 29, 2022. R4's January 2023, MAR indicated ULP-F performed the following treatments: -R4's Blood Glucose monitoring on January 20, 2023, and; -R4's Covid-19 symptom screening, including oxygen saturation monitoring on January 2, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 18, 19, 20, 22, 23, 25, 26, 27, and 30, 2023. ULP-I ULP-I was hired on July 19, 2021, to provide direct care services under the licensee's assisted living with dementia care license. ULP-I's training record lacked evidence ULP-I had been trained by an RN and demonstrated competency in medication administration.	01950		

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01950	Continued From page 47 R2 and R3's Medication Administration Record (MAR) dated December 2022, indicated in the morning (a.m.) on December 2, 5, 7, 10, 11, 14, 19, 20, 21, 2022, ULP-IJ completed COVID-19 symptoms check to include monitoring R2 and R3's oxygen saturation level. On February 1, 2023, at 10:35 a.m., licensed practical nurse (LPN)-J reviewed ULP-I and ULP-J's training records and stated she had completed the training and competency evaluations for ULP-F and ULP-I oxygen saturation monitoring. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated August 3, 2022, indicated prior to providing home care services to a resident, unlicensed personnel must satisfactorily complete a written, oral, or practical skills test for administering medications and treatments. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by review by evaluation supervisor on February 3, 2023, however noncompliance remains at a scope and level of level three, pattern (H).	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

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01960	Continued From page 48 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatment procedures were followed as directed to meet the resident's needs for one of one resident (R2) receiving blood pressure (BP) monitoring. 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 dementia, diabetes, and hypertension (high blood pressure). R2's service plan dated December 5, 2022, indicated services included medication administration, bathing, toileting, dressing, heavy cleaning/apartment inspection on every Tuesday, light cleaning every day, and laundry two (2) loads per week. R2's prescriber orders dated January 11, 2023, indicated to notify the nurse if R2's blood	01960		

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01960	Continued From page 49 pressure readings were over 160/90 or below 90/50 with an effective date of December 10, 2021. R2's Medication Administration Records (MAR) for December 2022, and January 2023, directed to notify the nurse if R2's blood pressure reading was over 160/90 or below 90/50. R2's MAR indicated the following BP readings outside of the parameters noted above: -December 6, 2022, R2's BP was 165/90 -December 7, 2022, 165/91 -December 8, 2022, R2's 175/100 -December 25, 2022, R2's BP at 2:00 p.m., and 8:00 p.m., were 194/105 -January 23, 2023, R2's BP was 177/96 R2's record lacked documentation indicating the nurse was notified of R2's blood pressure reading as directed on R2's MARs. On January 31, 2023, at 1:09 p.m., director of nursing/registered nurse (DON/RN)-C stated staff should document when the nurse was contacted regarding R2's high blood pressures and the nurse should document in the resident's record what actions were taken. DON/RN-C confirmed, R2's record lacked documentation the nurse was notified on the dates noted above. The licensee's policy Delegation of Nursing, Treatment or Therapy Tasks dated August 3, 2022, indicated each therapy or treatment administered must be documented in the client's record. When treatments or therapies are not administered as prescribed, the assigned provider must document the reason why it was not administered and any follow-up procedures that may have been provided to meet the client's	01960		

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01960	Continued From page 50 needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
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 hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. 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, 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	02040		

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02040	Continued From page 51 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted January 31, 2023, at approximately 11:00 a.m. with resident assisted living director (RALD)-A, director of patient care compliance (RN)-B, director of nursing/registered nurse (DON/RN)-C and maintenance (M)-G on the hazard vulnerability assessment for the physical environment of the facility. During interview, RALD-A, RN-B, DON/RN-C and M-G provided documentation of a general hazard vulnerability assessment but had not conducted a hazard vulnerability assessment of the physical environment with mitigation factors on and around the property to date at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are	02110		

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02110	Continued From page 52 person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representatives 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	02110		

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02110	Continued From page 53 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 for a capacity of 31 residents. R2's diagnoses included hypertension (high blood pressure). R3's diagnoses included dementia (mental decline). R4's diagnoses included diabetes and bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs). R2, R3, and R4's records did not include evidence or documentation the resident or resident's representative had received the policies and procedures related to dementia care as required. On January 31, 2023, at 11:33 a.m., administrator coordinator (AC)-D stated at the time of admission, the resident and or residents' representative were verbally informed of the licensee's dementia care policies. AC-D further stated there was no signed acknowledgement indicating the additional dementia care policies were offered or provided to the resident or residents' representative. The licensee's Assisted Living with Dementia Care Additional Required Policies dated August 1, 2021, indicated the additional dementia care policies and procedures must be provided to	02110		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BABBITT CAREFREE LIVING	1 CENTRAL BOULEVARD BABBITT, MN 55706

(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
02110	Continued From page 54 residents and the residents' legal and designated representative at the time of move-in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia [resident assisted living director (RALD)-A or director of nursing/registered nurse (DON/RN-C)], had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29103	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BABBITT CAREFREE LIVING	1 CENTRAL BOULEVARD BABBITT, MN 55706

(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
02140	Continued From page 55 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 was licensed as an assisted living facility with dementia care. During the entrance conference on January 30, 2023, at 10:48 a.m., RALD-A, registered nurse (RN)-B and DON/RN-C were unable to identify who was responsible for overseeing the dementia care training for staff. On January 30, 2023, at 1:10 p.m., RALD-A provided the evaluator with 15 contact hours of dementia care training for DON/RN-C. The evaluator and RN-B reviewed the commissioner of health's approved dementia care training courses. RN-B conformed RN-B, RALD-A, nor RN-C had completed an approved dementia training course. RN-B stated she planned on signing up all three of them up to complete the training courses. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140		
02170 SS=D	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;	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29103	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BABBITT CAREFREE LIVING	1 CENTRAL BOULEVARD BABBITT, MN 55706

(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 56 (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: (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 develop a comprehensive evaluation for activities and an individual activity plan (IAP) for one of three residents (R3) who received services under an assisted living with dementia care license.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29103	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BABBITT CAREFREE LIVING	1 CENTRAL BOULEVARD BABBITT, MN 55706

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02170	Continued From page 57 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: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. R3's diagnoses included dementia, degenerative joint disease, lower back pain, and hypertension (high blood pressure). R3's Life Enrichment Summary dated September 14, 2022, lacked the following required content: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, R3's record lacked the development of an individualized activity plan based on the activity evaluation. On January 31, 2022, at 1:38 p.m., registered nurse (RN)-B verified R3's record lacked a comprehensive activity evaluation and an activity plan that addressed all the required content noted above. RN-B stated R3 had poor memory recall and may not have been able to answer the	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29103	A. BUILDING: _____ B. WING _____	02/02/2023

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02170	Continued From page 58 questions needed to complete the activity evaluation. The licensee's ALDC Life Enrichment Programs, Activities and Outdoor Space policy dated August 1, 2021, indicated 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. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

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

Type: Full
Date: *01/30/23*
Time: 10:35:00
Report: 7983231022

Food and Beverage Establishment Inspection Report

Location:
Babbitt Carefree Living
1 Central Boulevard
Babbitt, MN55706
St. Louis County, 69

Establishment Info:
ID #: 0039226
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188272273
ID #:

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

The following orders were issued during this inspection.

5-200B Plumbing: cross connections

5-203.14I ** Priority 1 **

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

5/25/18: A SHUT-OFF VALVE WAS INSTALLED DOWNSTREAM OF THE ATMOSPHERIC VACUUM BREAKER AT THE MOP SINK, AND THE HOSE ON THE FAUCET HUNG BELOW THE SPILL RIM OF THE MOP SINK.

Comply By: 06/08/18

4-500 Equipment Maintenance and Operation

4-501.113

MN Rule 4626.0800 Maintain the flow pressure of the hot water sanitizing rinse in the warewashing machine within the range specified on the manufacturer's data plate but not less than 5 psi or more than 30 psi.

THE PRESSURE GAUGE INDICATED THAT THE FLOW PRESSURE OF THE SANITIZING RINSE WAS APPROXIMATELY 10 PSI.

Comply By: 03/01/23

Surface and Equipment Sanitizers

Chlorine: = 200 at N/A Degrees Fahrenheit
Location: Wiping cloth bucket in the kitchen.
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Reheating
Temperature: 202 Degrees Fahrenheit - Location: Egg roll.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: Raw shell egg in the Avantco single-door upright refrigerator.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Sliced cheese in the Avantco single-door upright refrigerator.
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 4 Degrees Fahrenheit - Location: Food in the walk-in freezer was frozen solid.
Violation Issued: No

Process/Item: Walk-In Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: Cut lettuce.
Violation Issued: No

Process/Item: Hot Holding
Temperature: 198 Degrees Fahrenheit - Location: White rice.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: 41 Degrees Fahrenheit - Location: Milk in the refrigerator compartment of the Maytag refrigerator/freezer.
Violation Issued: No

Process/Item: Refrigerator/Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the freezer compartment of the Maytag refrigerator/freezer was frozen solid.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 156 Degrees Fahrenheit - Location: Wash water temperature.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 194 Degrees Fahrenheit - Location: Rinse water temperature.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 160 Degrees Fahrenheit - Location: Utensil surface temperature.
Violation Issued: No

Type: Full
Date: *01/30/23*
Time: 10:35:00
Report: 7983231022
Babbitt Carefree Living

Food and Beverage Establishment Inspection Report

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

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GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, checking the calibration of the food thermometers, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) At the time of inspection, unpasteurized raw eggs were in use; however, two eggs are combined to prepare scrambled eggs for one consumer's serving only.

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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 7983231022 of 01/30/23.

Certified Food Protection Manager: Luke MacCoy

Certification Number: FM110218 Expires: 03/22/25

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed: 7983

Luke MacCoy
Person in Charge

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