Electronically Delivered

December 21, 2021

Administrator
Serenity Lvg Sltns Blackduck
441 4th Street Northeast
Blackduck, MN 56630

RE: Project Number(s) SL21164015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 15, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970

85 East Seventh Place
St. Paul, MN 55164-0970

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**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, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. 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,

Jeri Cummins , Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-302-6193 Fax: 651-215-9697

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21164 | A. BUILDING: _____ B. WING _____ | 12/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SERENITY LVG SLTNS BLACKDUCK | 441 4TH STREET NE BLACKDUCK, MN 56630 |

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| 0 000 | Initial Comments<br><br>Initial comments<br>*****ATTENTION******<br><br>ASSISTED LIVING LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL21164015<br>On December 13, 2021, through December 15, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 10 residents receiving services under the provider's Assisted Living license. | 0 000 | Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |

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| 0 470 | Continued From page 1 | 0 470 | | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements<br><br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a staffing plan was developed. This had the potential to affect all 10 residents and staff.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 470 | | |

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| 0 470 | Continued From page 2<br>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).<br><br>The findings include:<br><br>The licensee held an assisted living facility license. The facility was licensed for a bed capacity of 12 residents and had a current census of 10 residents.<br><br>The licensee failed to develop and implement a staffing plan for determining its staffing level that:<br>- included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>- ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>- ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility.<br><br>During the entrance conference on December 13, 2021, at approximately 12:20 p.m. a copy of the facility's staffing plan was requested from registered nurse (RN)-B.<br><br>On December 14, 2021, at approximately 2:55 p.m. RN-B provided a copy of the daily Facility Staffing Model which was posted in the main dining/living room area outside of the nursing office. RN-B stated the facility had always used the same staffing model. RN-B stated the | 0 470 | | |

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| 0 470 | Continued From page 3<br>staffing model could be changed based on the census number of the facility and/or the acuity of the residents. RN-B confirmed she had not developed a written staffing plan which included the above noted required content.<br><br>The licensee's Safety-Staffing and Scheduling Plan Policy dated August 1, 2021, indicated the licensee would assure qualified employees would be scheduled to meet operations requirements and the needs of the residents. The policy directed the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The policy indicated the staffing levels would be based on resident's needs, acuity level, ability of staff to meet needs timely, and be based on staff experience, training, and competency.<br><br>No further information was provided.<br><br>TIME PERIOD OF CORRECTION: Twenty-One (21) days | 0 470 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently; | 0 680 | | |

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| 0 680 | Continued From page 4<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review the licensee failed to prominently post the facility's emergency disaster plan. This had the potential to affect all 10 residents, staff and visitors of the licensee.<br><br>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).<br>The findings include:<br><br>On December 15, 2021, at approximately 12:05 p.m. during a tour of the facility with administrator (A)-D, A-D confirmed there was no signage or information regarding the licensee's disaster plan posted in a prominent area or elsewhere in the | 0 680 | | |

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| 0 680 | Continued From page 5<br>facility.<br><br>The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the facility would have in place a general emergency preparedness plan in alignment with facility's requirement to also comply with CMS Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines).<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 680 | | |
| 0 910 SS=D | 144G.50 Subd. 2 Contract information<br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility.<br>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:<br>(1) the facility and contracted service provider when applicable;<br>(2) the licensee of the facility;<br>(3) the managing agent of the facility, if applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with records reviewed. | 0 910 | | |

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| 0 910 | Continued From page 6<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's assisted living contract had not been revised to include the most current managing and authorized agent for the facility.<br><br>R1's Service Plan dated November 19, 2021, indicated services included assistance with activities of daily living, medication administration, brace/splint application and removal, incontinent care, housekeeping and laundry. R1's Assisted Living Contract dated August 1, 2021, listed Licensed Assisted Living Director (LALD)-E as the managing agent and authorized agent for the facility.<br><br>On December 14, 2021, at approximately 7:40 a.m. unlicensed personnel (ULP)-C was observed to administer R1 his scheduled morning medications.<br><br>On December 14, 2021, at approximately 1:55 p.m. Administrator (A)-D verified LALD-E was no longer an employee of the facility and R1's Assisted Living Contract should have been updated to reflect herself as the managing agent and authorized agent for the facility.<br><br>The licensee's Contract policy dated August 1, 2021, noted the Assisted Living Contract must | 0 910 | | |

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| 0 910 | Continued From page 7<br>include the managing agent of the facility, if applicable and the authorizing agent for the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 910 | | |
| 0 950 SS=D | 144.50 Subd. 3 Designation of representative<br><br>(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."<br><br>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the | 0 950 | | |

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| 0 950 | Continued From page 8<br>name and contact information of the designated representative.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to offer one of one resident (R1) the opportunity to a designated a representative with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's diagnoses included, but were not limited to, depression, hypertension (high blood pressure), mild cognitive impairment, diabetes, urge incontinence and atrial fibrillation (an irregular often fast heart rate).<br><br>R1's service plan dated October 19, 2021, indicated R1 received services which included medication administration, assistance with bathing, dressing, grooming, laundry and housekeeping.<br><br>R1's assisted living contract dated August 1, 2021, included a section to identify or to decline a designated representative. The designated representative section in R1's assisted living contract was not completed and there was no documentation indicating R1 declined to identify a representative. | 0 950 | | |

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| 0 950 | Continued From page 9<br><br>On December 14, 2021, at approximately 2:05 p.m. Administrator (A)-D confirmed R1's designated representative form was not filled out by identifying a designated representative or, indicating R1 declined to list a representative. A-D further stated there was no documentation in R1's record indicating R1 was offered and declined to list a designated representative.<br><br>The licensee 's Designated Representative policy dated August 1, 2021, indicated before or after time of execution of an assisted living contract, the facility will offer residents the opportunity to identify a designated representative in writing. A signed Designated Representative form must be filled out documenting the residents' choice in designated representative, and the form will be kept in the resident record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 950 | | |
| 0 970 SS=F | 144.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by: | 0 970 | | |

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| 0 970 | Continued From page 10<br><br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.<br><br>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).<br><br>The findings include:<br><br>On December 13, 2021, at approximately 1:05 p.m. a copy of the facility's assisted living contract was requested.<br><br>The assisted living contract included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. Page 15, section 2. of the contract indicated a resident would indemnify or hold harmless the provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. Page 16, section 4. of the contract indicated the provider was not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment unit or on provider's premises unless | 0 970 | | |

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| 0 970 | Continued From page 11<br>such injury, death or property damage occurred as a result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests.<br><br>On December 14, 2021, at approximately 2:00 p.m. Administrator (A)-D confirmed the above noted language was included in the assisted living contract which indicated the residents waived the facility's liability for health, safety, or personal property. A-D confirmed the assisted living contract was a template contract used for all residents.<br><br>The licensee's Contracts policy dated August 1, 2021, noted waivers of liability were prohibited. The contract must not include a waiver of facility liability for the health and safety or personal property of a resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 970 | | |
| 01420 SS=E | 144G.62 Subd. 2 Delegation of assisted living services<br><br>(b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel | 01420 | | |

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| 01420 | Continued From page 12 | 01420 | | |

must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided written instructions in the resident's record for the delegated task provided by the unlicensed personnel (ULP) for two of two residents (R1, R4) who utilized a sit to stand lift for transfers with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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:

R1 and R4's record lacked evidence of specific written instructions for the ULP to follow when transferring the resident with a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability) to include the size of the sling to be used.

R1
R1's diagnoses included, but were not limited to, depression, hypertension (high blood pressure), mild cognitive impairment, diabetes, urge

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incontinence and atrial fibrillation (an irregular often fast heart rate).

R1's Master Care Plan and Service Plan dated September 16, 2021, and November 19, 2021, respectively indicated the resident required assistance with transferring and used a sit to stand lift for all transfers. R1's Assessment completed by RN-B on September 16, 2021, indicated R1 required a sit to stand lift for all transfers. On December 7, 2021, R1's weight was 223.5 pounds.

On December 14, 2021, at approximately 7:10 a.m. ULP-C and ULP-D were observed to assist R1 with personal cares and to transfer R1 from the bed to the toilet; and then from the toilet to his wheelchair using a sit to stand lift. The sling size used was a large.

R4
R4's diagnoses included, but were not limited to dementia, hypertension, and chronic insomnia.

R4's Master Care Plan and Service Plan dated November 5, 2021, and December 4, 2021, respectively indicated the resident required assistance with transferring and used a sit to stand lift. R4's assessment completed by RN-B on November 5, 2021, indicated R4 utilized a sit to stand lift for transfers. On December 2, 2021, R4's weight was 94.5 pounds.

On December 14, 2021, at approximately 8:00 a.m. ULP-C and ULP-D were observed to transfer R4 with the sit to stand lift from the bed to the wheelchair. ULP-C and ULP-D assisted R4 to a seated position on the side of the bed. ULP-C and ULP-D placed the butterfly sling under R4's arms and upper torso and secured the

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| 01420 | Continued From page 14 | 01420 | | |

buckle in the front of the sling. ULP-D positioned the sit to stand lift in front of R4; ULP-C and ULP-D attached the sling to the lift; ULP-C placed R4's feet on the base of the stand; and ULP-D instructed R4 to grasp and hang on to the handles of the sit to stand lift, which R4 did after some guidance. ULP-D activated the sit to stand lift and raised R4 up off the bed; R4 was not fully erect and was observed to be in more of a sitting/squatting position with her knees up and feet not on the base plate of the stand and the butterfly sling moved up under R4's armpits. ULP-D and ULP-C instructed R4 to put her feet on the base plate and to stand, which R4 complied putting her in more of an erect position. ULP-C positioned the wheelchair behind R4 and ULP-D lowered R4 into the wheelchair. ULP-D and ULP-C removed the sling from R4's upper torso. The sling which was in R4's room was labeled as a size medium.

R1 and R4's record lacked evidence of specific written instructions for the ULP to follow when transferring the resident with a sit to stand lift to include the size of the sling to be used.

On December 14, 2021, at approximately 1:45 p.m. RN-B confirmed R1 and R4's record or the licensee's Stand Device policy dated June 1, 2018, did not include specific written instructions for the ULP to follow when transferring the resident with a sit to stand to include the size of the sling to be used for each resident.

The PA800 Operator's Manual (sit to stand lift) dated March 2019, included a Lift/Transfer Assessment Form algorithm tool to be used which included documentation of sling size. The manual's Sling Size Chart indicated a large sling should be used for a person weighing 200-325

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| 01420 | Continued From page 15<br>pounds; medium sling should be used for a person weighing 125-200 pounds; small sling should be used for a person weighing 100-125 pounds, and an extra small sling should be used for a person weighing 75-100 pounds.<br><br>The licensee's Delegated of Assisted Living Services policy dated August 1, 2021, indicated the RN or licensed health professional would document instructions for the delegated tasks in the resident's record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01420 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; | 01470 | | |

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| 01470 | Continued From page 16<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure one of two employees | 01470 | | |

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| 01470 | Continued From page 17<br>(registered nurse (RN)-B) received orientation to assisted living facility licensing to include all the required topics with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>RN-B's employee record lacked evidence to indicate RN-B had received the required orientation.<br><br>RN-B started employment on March 14, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>RN-B's record lacked the following required orientation content:<br>- an introduction and review of the facilities policies and procedures related to the provision of assisted living services by the individual staff person; and<br>- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br><br>On December 14, 2021, at approximately 3:45 p.m. RN-B stated she thought she had completed some of the assisted living orientation at their corporate training, although was unable to provide the requested documentation. | 01470 | | |

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| 01470 | Continued From page 18<br><br>On December 15, 2021, at approximately 9:50 a.m. administrator (A)-D verified RN-B had not completed the above noted orientation as required.<br><br>An orientation training policy was requested but was not received.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01470 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of one resident's (R1) inhalant medications had an original label and failed to monitor for expired stock medications.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). | 01890 | | |

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| 01890 | Continued From page 19<br><br>The findings include:<br><br>On December 13, 2021, at approximately 1:40 p.m. the locked medication cart was reviewed with registered nurse (RN)-B and unlicensed personnel (ULP)-C. The following was observed and confirmed by RN-B.<br><br>ORIGINAL PRESCRIPTION LABELS<br>R1<br>R1'S activated Symbicort 160/4.5 (bronchodilator) inhaler and Spiriva Respimat 2.5 micrograms (mcg) (bronchodilator) inhaler lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued.<br><br>EXPIRED MEDICATIONS<br>In the stock medication drawer of the medication cart was one triple antibiotic ointment tube with an expiration date of June 2020.<br><br>On December 13, 2021, directly following the above observation RN-B confirmed all medications should have their original prescription label on them or the inhalers should be stored in their box with the prescription label attached. RN-B stated she reviews the medication cart once a week to look for expired medications and missed finding the triple antibiotic ointment.<br><br>The licensee's Medication Storage policy dated August 1, 2021, indicated prescription drugs must be kept in the original prescription label with legible information.<br><br>The licensee's Medication Disposal policy dated | 01890 | | |

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| 01890 | Continued From page 20<br>August 1, 2021, indicated expired medications managed by the facility would be disposed of according to the accepted practices of the Minnesota board of Pharmacy.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 02310 SS=E | 144G.91 Subd. 4 Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to accepted health care and medical, or nursing standards for two of two residents (R1, R4) who utilized a sit to stand lift for transfers with records reviewed.<br><br>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 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).<br><br>The findings include: | 02310 | | |

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| 02310 | Continued From page 21<br><br>R1 and R4's transfer assessment for use of the sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability) did not include an assessment for proper sling size per manufacturer's instructions.<br><br>R1<br>R1's diagnoses included, but were not limited to, depression, hypertension (high blood pressure), mild cognitive impairment, diabetes, urge incontinence and atrial fibrillation (an irregular often fast heart rate).<br><br>R1's Master Care Plan and Service Plan dated September 16, 2021, and November 19, 2021, respectively indicated the resident required assistance with transferring and used a sit to stand lift for all transfers. R1's Assessment completed by registered nurse (RN)-B on September 16, 2021, indicated R1 required a sit to stand lift for all transfers. On December 7, 2021, R1's weight was 223.5 pounds.<br><br>On December 14, 2021, at approximately 7:10 a.m. unlicensed personnel (ULP)-C and ULP-D were observed to assist R1 with personal cares and to transfer the resident from the bed to the toilet; and then from the toilet to his wheelchair using the sit to stand lift. ULP-C and ULP-D assisted R1 to a seated position on the side of the bed; and put on the resident's shoes. ULP-D positioned the sit to stand lift in front of R1; ULP-C and ULP-D placed the butterfly sling under R1's arms and upper torso (trunk of the body); secured the buckle in the front of the sling; and attached the sling to the lift. ULP-C positioned R1's feet on the base of the stand and instructed the resident to grasp and hang on to the handles of the sit to stand lift, which R1 complied. ULP-C | 02310 | | |

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| 02310 | Continued From page 22 | 02310 | | |

activated the sit to stand lift and raised R1 into more of a standing position. ULP-C and ULP-D moved R1 into the bathroom; lowered him on to the toilet; removed the torso sling and proceeded to assist R1 with personal cares, toileting, and dressing. At approximately 7:30 a.m., ULP-C and ULP-D followed the same procedure and assisted R1 from the bathroom to his wheelchair using the sit to stand lift for transferring. The size of R4's sling was labeled large.

R1's Assessment and Master Care Plan listed above did not include instructions regarding what size sling should be used when transferring R1 with the sit to stand lift.

R4
R4's diagnoses included, but were not limited to dementia, hypertension, and chronic insomnia.

R4's Master Care Plan and Service Plan dated November 5, 2021, and December 4, 2021, respectively indicated the resident required assistance with transferring and used a sit to stand lift. R4's Assessment completed by RN-B on November 5, 2021, indicated R4 utilized a sit to stand lift for transfers. On December 2, 2021, R4's weight was 94.5 pounds.

On December 14, 2021, at approximately 8:00 a.m., ULP-C and ULP-D were observed to transfer R4 with the sit to stand lift from the bed to the wheelchair. ULP-C and ULP-D assisted R4 to a seated position on the side of the bed. ULP-C and ULP-D placed the butterfly sling under R4's arms and upper torso and secured the buckle in the front of the sling. ULP-D positioned the sit to stand lift in front of R4; ULP-C and ULP-D attached the sling to the lift; ULP-C placed R4's feet on the base of the stand; and ULP-D

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21164 | A. BUILDING: _____ B. WING _____ | 12/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SERENITY LVG SLTNS BLACKDUCK | 441 4TH STREET NE BLACKDUCK, MN 56630 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 23 | 02310 | | |

instructed R4 to grasp and hang on to the handles of the sit to stand lift, which R4 did after some guidance. ULP-D activated the sit to stand lift and raised R4 up off the bed; R4 was not fully erect and was observed to be in more of a sitting/squatting position with her knees up and feet not on the base plate of the stand and the butterfly sling moved up under R4's armpits. ULP-D and ULP-C instructed R4 to put her feet on the base plate and to stand, which R4 complied putting her in more of an erect position. ULP-C positioned the wheelchair behind R4 and ULP-D lowered R4 into the wheelchair. ULP-D and ULP-C removed the sling from R4's upper torso. The sling which was in R4's room was labeled as a size medium.

R4's Assessment and Master Care Plan listed above did not include instructions regarding what size sling should be used when transferring R4 with the sit to stand lift.

On December 14, 2021, at approximately 8:20 a.m. ULP-D stated each resident had their own sling. ULP-D stated R1 used a large sized sling and R4 used a small sized sling. As noted above, R1's sling size was observed to be large and R4's sling was observed to be a medium.

On December 14, 2021, at approximately 1:10 p.m. ULP-D verified with this surveyor and RN-B the sling assigned to be used for R4 was a size medium.

On December 14, 2021, at approximately 1:40 p.m. RN-B confirmed the assessment for the use of the sit to stand did not include an evaluation of what sized sling should be used for each resident. RN-B stated it was her expectation that the manufacturer instructions for the sit to stand

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21164 | A. BUILDING: _____ B. WING _____ | 12/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SERENITY LVG SLTNS BLACKDUCK | 441 4TH STREET NE BLACKDUCK, MN 56630 |

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|---|---|---|---|---|
| 02310 | Continued From page 24<br>be followed.<br><br>The PA800 Operator's Manual (sit to stand lift) dated March 2019, included a Lift/Transfer Assessment Form algorithm tool to be used which included documentation of sling size. The manual's Sling Size Chart indicated a large sling should be used for a person weighing 200-325 pounds; medium sling should be used for a person weighing 125-200 pounds; small sling should be used for a person weighing 100-125 pounds, and an extra small sling should be used for a person weighing 75-100 pounds.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02310 | | |

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

Type: Full
Date: *12/14/21*
Time: 13:00:39
Report: 1002211211

# Food and Beverage Establishment Inspection Report



**Location:**
Serenity Lvg Sltns Blackduck
441 4th Street Ne
Blackduck, MN56630
Beltrami County, 04

**Establishment Info:**
ID #: 0039083
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 2188354564
ID #:

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

No NEW orders were issued during this inspection.

**Surface and Equipment Sanitizers**

Utensil Surface Temp: = at 160 Degrees Fahrenheit
Location: THERMOLABELS - DISH MACHINE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: AMBIENT TEMP - ARCTIC AIR COOLER
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: AMBIENT TEMP - ARCTIC AIR FREEZER
Violation Issued: No

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

HFID #21164

Discussion:

Handwashing - fact sheet and sign provided with report

Employee illness - fact sheet, decision guide and log provided with report

Safe cleaning, sanitizing and manual warewashing - fact sheet and sign provided with report

Thermometer calibration - method and frequency

# Food and Beverage Establishment Inspection Report



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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1002211211 of 12/14/21.

Certified Food Protection Manager: Samuel J. Bender

Certification Number: FM108036 Expires: 08/16/24

**Inspection report reviewed with person in charge and emailed.**

Signed: _____

Samuel J. Bender
Manager

Signed: _____

Cassandra Hua
Public Health Sanitarian III
218-308-2142
Cassandra.Hua@state.mn.us