Electronically Delivered

April 25, 2025

Licensee
Falls Landing Assisted Living
1101 North Hiawatha Avenue
Pipestone, MN 56164

RE: Project Number(s) SL30347016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

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 may be 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.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program- $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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.

To submit a hearing request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

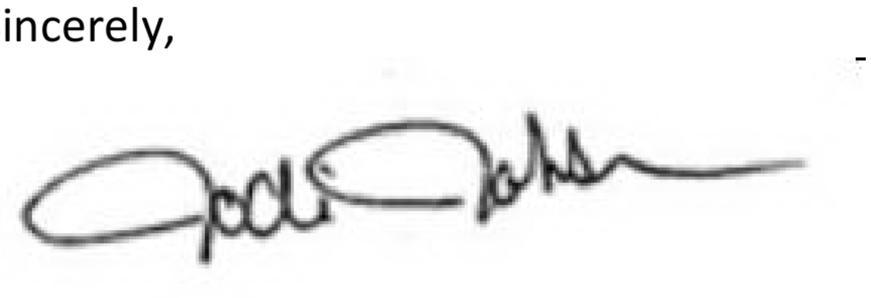
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30347	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

(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 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: SL30347016-0 On April 1, 2025, through April 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 20 residents; 20 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 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 evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control with proper hand hygiene for two of two employees (unlicensed personnel (ULP)-C, licensed assisted living director (LALD)-A). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: ULP-C On April 1, 2025, during continuous observation, the surveyor observed unlicensed personnel	0 510		

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0 510	Continued From page 2 (ULP)-C completing the following tasks: - 12:00 p.m. ULP-C administered oral medications to R6; ULP-C did not wash hands or use hand sanitizer, - 12:05 p.m. ULP-C administered oral medication to R2 and used hand sanitizer.. - 12:09 p.m. ULP-C administered oral medication to R4; ULP-C did not wash hands or use hand sanitizer, - 12:11 p.m. ULP-C administered oral medication to R5; ULP-C did not wash hands or use hand sanitizer, - 12:13 p.m. ULP-C administered oral medications to R8; ULP-C did not wash hands or use hand sanitizer, - 12:14 p.m. ULP-C administered oral medications to R9; ULP-C did not wash hands or use hand sanitizer, - 12:15 p.m. ULP-C administered oral medications to R10; ULP-C did not wash hands or use hand sanitizer, - 12:17 p.m. ULP-C administered oral medications to R8 and used hand sanitizer. - 12:21 p.m. ULP-C administered oral medications to R5; ULP-C did not wash hands or use hand sanitizer, - 12:29 p.m. ULP-C assisted R3, to transfer and ambulate to his room with hands on assistance, ULP-C did not wash hands or use hand sanitizer, - 12:40 p.m. ULP-C removed R5's insulin from the medication cart, entered R5's room, put on gloves, administered insulin, removed gloves, and returned to the medication cart. ULP-C did not wash hands or use hand sanitizer. - 12:45 p.m. ULP-C removed diclofenac ointment from the med cart, entered R2's room, put on gloves, administered the ointment, removed gloves, and sanitized hands. -12:55 p.m. ULP-C put on gloves, washed R12's right eye with a warm wash cloth, administered	0 510		

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0 510	Continued From page 3 antibiotic eye drops, removed gloves, ULP-C did not wash hands or use hand sanitizer. - ULP-C responded to R8's call light, assisted him to transfer onto the toilet, waited and assisted in transferring him off the toilet,; ULP-C used hand sanitizer. - 1:08 p.m. ULP-C put on gloves, administered insulin to R1, and removed gloves. ULP-C did not wash hands or use hand sanitizer. LALD-A On April 2, 2025, during continuous observation, the surveyor observed LALD-A completing the following tasks: - 7:50 a.m. LALD-A returned from giving oral medications to a resident sitting in the dining room, LALD-A did not wash hands or use hand sanitizer, - LALD-A administered oral medications to R10, LALD-A did not wash hands or use hand sanitizer, - 8:03 a.m. LALD-A administered oral medications to R9, did not wash hands or use hand sanitizer, - 8:50 a.m. LALD-A put on gloves, administered Victoza (injectable diabetes medications), inhaled medication, and medicated lotion to R4. LALD-A removed gloves, did not wash hands or use hand sanitizer, - LALD-A removed R1's insulin from the medication cart, went to R1's room, put on gloves, injected the insulin, removed gloves and returned to the medication cart to document administration. LALD-A did not wash hands or use hand sanitizer. On April 2, 2025, at 9:45 a.m., LALD-A stated she forgot to wash hands after using gloves and contact with the residents and should have used hand sanitizer between residents when	0 510		

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0 510	Continued From page 4 administering medications. On April 2, 2024, at 9:58 a.m., clinical nurse supervisor (CNS)-B stated staff should wash hands all the time, such as when dealing with food, after giving injectable medications, after contact with body fluids, and after removing gloves. Staff should use hand sanitizer in between residents when completing medication administration. The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated "Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: · Before, during, and after preparing food · Before eating food · Before and after caring for someone who is sick · Before and after treating a cut or wound · After using the toilet · After changing diapers or cleaning up after someone who has used the toilet · After blowing your nose, coughing, or sneezing · After touching an animal or animal waste · After handling pet food or pet treats · After touching garbage" Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations. Hand Hygiene and Gloves When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. Alcohol-Based Hand Sanitizers (ABHS) ABHS should not be used as a replacement for proper hand washing when hands are visibly	0 510		

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0 510	Continued From page 5 soiled. However, if hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060		

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01060	Continued From page 6 may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with all the required content to the resident, legal representative, and designated representative, for an emergency relocation for one of one resident (R3). 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: The licensee's Discharge or Deceased Resident Roster indicated R3's date of discharge or death occurred on February 26, 2025, and R3 was	01060		

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01060	Continued From page 7 transferred to a hospital. R3's Discharge summary was dated February 18, 2025. R3's Notification of Emergency Relocation form indicated on February 14, 2025, at 11:15 a.m., R3 was transferred to the hospital with pneumonia. The form lacked contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. R3's record included a fax transmission report that R3's Notification of Emergency Relocation form had been sent to the ombudsman. R3's record did not have evidence the form was provided to the resident and/or the resident's responsible party as required. On April 2, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated when a resident is sent to the hospital, the facility fills out the Notification of Emergency Relocation form and provides it to the ombudsman if the resident is out of the facility for four days. CNS-B stated she was unaware the form needed to be provided to the resident and/or the resident's responsible party as soon as practicable. CNS-B stated since the document only went to the ombudsman she was unaware the form needed to have contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. The licensee's 1.23 Emergency Relocation policy dated July 26, 2022, identified: 1. In the event of an emergency relocation, [licensee name] will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the	01060		

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01060	Continued From page 8 location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities d. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known, and e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. The facility will provide contact information for the agency to which the resident may submit an appeal. 4. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620		

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01620	Continued From page 9 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment including all required information in the Uniform Assessment Tool for one of one resident (R1) every 90 days as required. 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).	01620		

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01620	Continued From page 10 The findings include: On April 1, 2025, at 1:08 p.m., the surveyor observed unlicensed personnel (ULP)-C administering medication to R1. R1's service plan dated September 27, 2024, indicated R1's services included medication administration, blood glucose monitoring, and compression stockings. R1's record included the following assessments: - Uniform Assessment Tool completed September 27, 2022; - 90 Day Assessment II completed on September 17, 2024, - 90 Day Assessment II completed on December 12, 2024; and - 90 Day Assessment II completed on March 16, 2025. The 90 day Assessment II did not include all information required on the Uniform Assessment Tool On April 3, 2025, at 10:04 a.m., clinical nurse supervisor (CNS)-B stated she only completes the Uniform Assessment Tool on admission for all the residents. Any subsequent assessments are completed using the 90 Day Assessment II document. CNS-B stated she was unaware the Uniform Assessment Tool need to be completed for all 90 day assessments. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated July 26, 2022, indicated "The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required,"	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30347	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

(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
01620	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01750 SS=D	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, 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 observation, interview, and record review, the licensee failed to ensure the resident record specified, in writing, specific instructions for diclofenac gel (pain relief) for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30347	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

(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
01750	Continued From page 12 The findings include: On April 1, 2024, at 12:45 p.m., ULP-C removed R2's diclofenac gel from the med cart. ULP-C checked the medication label to the medication administration record (MAR). ULP-C stated neither the label or the MAR specified where the diclofenac was to be applied; therefore, she would ask R2 where they wanted it applied. R2 typically requested it on her lower back, her right knee and her left shoulder. ULP-C went to R2's room and asked her where she would like the diclofenac. R2 showed ULP-C her lower back, her right knee and her left shoulder and ULP-C. ULP-C put some of the gel on a gloved hand and rubbed the gel onto the lower back, then put some of the gel on a gloved hand and rubbed the gel onto the right knee, then put some of the gel on a gloved hand and rubbed the gel onto the left shoulder. R2 was admitted on March 20, 2025, and her diagnoses included chronic back pain, and fibromyalgia. R2's service plan dated March 21, 2025, indicated R2 received services including medication administration. R2's physician orders dated March 18, 2025, included Diclofenac gel apply 4 grams topically four times a day. The physicians order did not identify the location for the diclofenac R2's MAR dated April 1-3, 2025, included diclofenac apply 4 grams topically 4 times a day. The MAR did not include specific instructions from the nurse on the location for the diclofenac or to ask R2 where they wanted the diclofenac	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30347	A. BUILDING: _____ B. WING _____	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

(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
01750	Continued From page 13 gel. On April 2, 2025, at 9:54 a.m., clinical nurse supervisor (CNS)-B stated she had requested clarification for the gel from the physician. Until clarification was received, staff were to ask R2 where she would like the diclofenac and staff were to apply it where R2 requested. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated when medication administration is delegated to unlicensed personnel the registered nurse would specify, in writing, specific instructions for medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to ensure medications were administered according to policy and accepted standards of practice for two of two residents (R5, R1) with insulin, one of one	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30347	A. BUILDING: _____ B. WING _____	04/03/2025

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02320	Continued From page 14 resident (R2) with diclofenac gel, and one of one resident with an inhaler (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 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Insulin administration R1 R1's diagnoses included diabetes. R1's service plan dated September 27, 2024, identified R1's services included medication administration. R1's prescriber orders dated October 1, 2024, included Novolog insulin 5 units subcutaneous three times a day with meals. On April 1, 2025, at 1:08 p.m., unlicensed personnel (ULP)-C removed the cap from the Novolog insulin pen, placed a pen needle on the insulin pen, dialed the pen and realized there were only 2 units remaining. ULP-C retrieved a new Novolog insulin pen, placed a pen needle on the pen, and dialed the insulin pen to 3 units. ULP-C then cleaned the injection site and injected the 2 units from the first pen, immediately removing the needle from the skin. ULP-C injected the 3 units from the second pen and immediately removed the needle from the skin.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 15 ULP-C did not clean the insulin pen ports prior to putting on the needle, did not prime the insulin pens, and did not hold the needle in the skin the appropriate amount of time after the injections. On April 2, 2025, at approximately 8:55 a.m., licensed assisted living director (LALD)-A removed the cap from the Novolog insulin, placed a pen needle on the insulin pen, dialed the insulin pen to 5 units, cleaned the injection site, administered the insulin and held the needle in for the appropriate amount of time. LALD-A did not clean the port of the insulin pen prior to placing the pen needle, and did not prime the insulin pen. R5 R5's diagnoses included diabetes. R5's service plan dated August 1, 2024, identified R5's services included medication administration. R5's medication administration record (MAR) dated April 1-3, 2025, included lispro (Humalog) insulin inject 30 units at 12:30 p.m. On April 1, 2025, at 12:40 p.m., ULP-C removed the cap from the lispro insulin pen, placed a pen needle on the insulin pen, dialed the pen to 30 units, cleaned the injection site, injected the insulin and immediately removed the needle from the skin. ULP-C did not clean the insulin pen ports prior to putting on the needle, did not prime the insulin pens, and did not hold the needle in the skin the appropriate amount of time after the injections. On April 2, 2025, at 9:45 a.m. LALD-A stated she was trained when administering insulin she should have cleaned the port and prime the insulin pen, but she had forgotten those steps.	02320		

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02320	Continued From page 16 On April 2, 2025, at 9:50 a.m., clinical nurse supervisor (CNS)-B stated when administering insulin, staff were trained to use an alcohol swab on the port of the insulin pen, prime the insulin pen with 2 units of insulin, and hold the needle in the skin for 10 seconds after injecting the insulin. Diclofenac gel R2 R2 was admitted on March 20, 2025, with chronic back pain, and fibromyalgia. R2's service plan dated March 21, 2025, indicated R2 received medication administration. R2's physician orders dated March 18, 2025, included diclofenac gel apply 4 grams topically four times a day. The physicians order failed to identify the location for the diclofenac R2's MAR dated April 1-3, 2025 included diclofenac apply 4 grams topically 4 times a day. The MAR failed to identify the location for the diclofenac. On April 1, 2025, at 12:45 p.m., ULP-C removed R2's diclofenac gel from the medication cart. ULP-C checked the medication label to the medication administration record (MAR). ULP-C stated neither the label or the MAR specified where the diclofenac was to be applied; therefore, she would ask R2 where they wanted it applied. ULP-C stated R2 typically requests it on her lower back, her right knee and her left shoulder. ULP-C went to R2's room and asked her where she would like the diclofenac. R2 showed ULP-C her lower back, her right knee and her left shoulder. ULP-C put some of the gel onto her gloved hand	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 17 and rubbed the gel onto the lower back, then put some of the gel on her gloved hand and rubbed the gel onto the right knee, then put some of the gel on her gloved hand and rubbed the gel onto the left shoulder. ULP-C stated typically there was a "measuring thing" attached to the tube of diclofenac by a rubber band; however, it was missing and she was unable to find it. She had checked in the past how much to put on her finger so she just used her finger to measure the diclofenac. ULP-C found an extra measuring strip provided by the manufacturer in R1's space in the medication cart, used a Lysol wipe to wipe down the measuring strip and attached it to R2's tube of diclofenac with a rubber band. On April 2, 2025, at 9:54 a.m., clinical nurse supervisor (CNS)-B stated she had requested clarification for the gel from the physician. Until clarification was received, staff were to ask R2 where she would like the diclofenac and staff were to apply it where R2 requested. Staff were to use the measuring strip provided by the manufacturer when administering the diclofenac so they administer the correct dosage. Inhaler R4 R4's diagnoses included chronic obstructive pulmonary disease and asthma. R4's service plan dated August 1, 2024, indicated R4 received medication administration. R4's physician orders dated September 30, 2024, included budesonide formeterol (used to help control the symptoms of asthma and improve lung function) two puffs by mouth twice a day.	02320		

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02320	Continued From page 18 On April 2, 2025, at 8:50 a.m., LALD-A brought R4's budesonide formeterol inhaler and a spacer to R4, LALD-A connected the spacer to the inhaler and administered the medication, prompting R4 when to breathe in the medication. LALD-A did not cue or assist R4 to rinse her mouth after using the inhaler. On April 2, 2025, at 9:45 a.m., LALD-A stated she knew she was supposed to have R4 rinse and spit after using the inhaler but had forgotten about it. On April 2, 2025, at 9:54 a.m., CNS-B stated staff had been trained to have residents rinse their mouth and spit it out after using an inhaler. The licensee's undated, 2.23 Injections - Subcutaneous policy included the following steps: 15. Remove the pen cap and clean with an alcohol wipe 17. Prime the pen per manufacturer instructions (see MAR); to remove any air bubbles that may be present 21. Pinch the skin and inject the needle into the subcutaneous skin, waiting 8-10 seconds before removing from the injection site. The licensee's 7.42 Topical Application of Ointment & Cream dated August 1, 2021, indicated topical ointments and creams are to be applied per the physicians orders. The NovoLog injection FlexPen Instructions for Use dated revised February 2015, noted: A. Pull off the pen cap, wipe the rubber stopper with an alcohol swab. B. Attach the needle E. Turn the dose selector to select 2 units F: Hold your NovoLog FlexPen with the needle	02320		

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02320	Continued From page 19 pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. Humalog KwikPen instructions for use dated revised March 2013, noted: Step 1: Remove the insulin cap and wipe the rubber seal with an alcohol swab Step 5: Turn the Dose Knob to select 2 units. Step 6: Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top. Step 7: Hold your Pen with Needle pointing up. Push the Dose Knob in until it stops, and "0" is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. ? A stream of insulin should be seen from the needle. Step 11: Put your thumb on the Dose Knob and push the Dose Knob in until it stops. Hold the Dose Knob in and slowly count to 5. Step 12: Pull the Needle out of your skin. The Voltaren (diclofenac) gel instructions for use dated revised May 2016, identified to use the dosing card to correctly measure each dose. Place the dosing card on a flat surface so that you can read the print. Squeeze the gel onto the dosing card evenly, up to the 2-gram line (a 2.25-inch length of gel) or 4-gram line (a 4.5 inch length of gel). Make sure that the gel covers the 2-gram or 4-gram area of the doing card. After using the dosing card, hold end with fingertips, rinse and dry. Store the dosing card until next use. Symbicort (budesonide formeterol) prescribing instructions dated February 2009, included 12.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 20 After you finish taking SYMBICORT (two puffs), rinse your mouth with water. Spit out the water. Do not swallow it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Food, Pools, and Lodging Services
12 Civic Center Plaza
Mankato, MN 56001
507-344-2700

Type: Full
Date: *04/03/25*
Time: 10:57:48
Report: 7990251007

Food and Beverage Establishment Inspection Report

Location:

Falls Landing Assisted Living
1101 North Hiawatha Avenue
Pipestone, MN56164
Pipestone County, 59

Establishment Info:

ID #: 0038319
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075626648
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

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: Sanitizer Bucket
Violation Issued: No

Hot Water: = at 171 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: White Arctic Air Reach in Cooler Yogurt
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Kratos Reach In Cooler Sausage
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Norlake Reach In Cooler Turkey
Violation Issued: No

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

We discussed handwashing, barehand contact, and norovirus prevention. An Employee Illness log was onsite.

Type: Full
Date: *04/03/25*
Time: 10:57:48
Report: 7990251007
Falls Landing Assisted Living

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 7990251007 of 04/03/25.

Certified Food Protection Manager: Jennifer R. Currier

Certification Number: 63285 Expires: 06/17/27

Signed: Emailed
Establishment Representative

Signed: Bryan D. Dorhi
7990
651-201-4500
health.foodlodging@state.mn.us

Report #: 7990251007

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
12 Civic Center Plaza
Mankato, MN 56001

No. of RF/PHI Categories Out	0	Date	04/03/25
No. of Repeat RF/PHI Categories Out	0	Time In	10:57:48
Legal Authority MN Rules Chapter 4626		Time Out	

Falls Landing Assisted Living	Address: 1101 North Hiawatha Avenue	City/State: Pipestone, MN	Zip Code: 56164	Telephone: 5075626648
License/Permit #: 0038319	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

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

Inspector (Signature) Bryn D. Dorhi