DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 4, 2022

Administrator
Pines III Assisted Living
50 East St. Marie Street
Duluth, MN 55803

RE: Project Number(s) SL20866015

Dear Administrator:

On February 24, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 17, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 651-508-2791| Fax: 218-332-5196

HHH

Electronically Delivered

January 25, 2022

Administrator
Pines III Assisted Living
50 East Saint Marie Street
Duluth, MN 55803

RE: Project Number(s) SL20866015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 17, 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), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00
St - 0 - 1620 - 144g.70 Subd. 2 - Initial Reviews, Assessments, And Monitoring = $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up 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 of the correction order receipt date.

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

Please address your cover letter for general Free from Maltreatment reconsideration

reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

requests should addressed to:
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Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. 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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20866	A. BUILDING: _____ B. WING _____	12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES III ASSISTED LIVING	50 EAST ST. MARIE STREET DULUTH, MN 55803

(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 Initial comments ******ATTENTION****** ASSISTED LIVING 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: SL20866015 On December 14, 2021, through December 17, 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 53 residents receiving services under the provider's Assisted Living with Dementia Care license. On December 17, 2021, the immediacy of correction order 1620 has been removed, however non-compliance remains at a scope and level of D.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (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 (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; (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: (i) awake; (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; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure their required staffing plan was followed. This had the potential to affect all 53 clients in the assisted living facility, staff and any visitors of the licensee. 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	0 470		

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0 470	Continued From page 2 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 Direct Care Staffing Plan and Evaluation dated July 14, 2021, indicated there were 30 residents who needed assistance and the planned team members for the area was three unlicensed personnel (ULP) on the day shift, three ULP on the afternoon shift and one ULP on the night shift. On December 14, 2021, at approximately 9:00 a.m. licensed assisted living director (LALD)-A and interim clinical director (ICD)-B both indicated the licensee had a staffing plan. LALD-A indicated they staffed three ULP on the day shift, three ULP on the afternoon shift and one ULP on the night shift. The staffing for December 14, 2021, posted by the main entry indicated three ULP on the day shift, two ULP on the afternoon shift, and one ULP on the night shift. Review of the Resident Rosters provided during the entrance conference on December 14, 2021, at approximately 10:30 a.m. indicated there were 40 residents receiving assisted living services and 13 residents only receiving housing. The December Schedule for afternoons indicated there were only two ULP scheduled for the afternoon shift on December 2, 3, 7, 12, 13, 14, 16, and 17, 2021.	0 470		

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0 470	Continued From page 3 On December 15, 2021, at approximately 10:00 a.m. ULP-D stated often on the afternoon shift there were only two ULP working. ULP-D stated she had worked the afternoon shift when only two ULP worked and it was very difficult to get all required tasks completed. The staffing for December 17, 2021, posted by the main entry indicated three ULP on the day shift, two ULP on the afternoon shift, and one ULP on the night shift. On December 17, 2021, at 7:55 a.m. LALD-A confirmed two ULP were scheduled for the afternoon shift on December 17, 2021. LALD-A confirmed that often there are only two ULP on the afternoon shift, and the licensee's staffing plan addressed the need for three staff on the afternoon shift. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated July 25, 2021, indicated the organization will have an implemented, written staffing plan. The staffing plan will be evaluated for the appropriateness of staffing levels in the facility and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

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0 480	Continued From page 4 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all 53 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 14, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and 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. This had the potential to affect all 53 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RESIDENT COVID-19 MONITORING AND SCREENING	0 510		

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0 510	Continued From page 6	0 510		

The Minnesota Department of Health (MDH) guidance titled, "COVID-19 Toolkit," dated March 8, 2021, indicated all residents should be actively screened for fever and respiratory symptoms at least daily, and daily pulse oximeter screening was recommended. Charting all clinical measurements and symptoms for each resident was recommended.

The licensee lacked evidence R3 and R6 were monitored for oxygen saturation levels, temperatures and screened for COVID-19 symptoms daily.

R3
R3's diagnoses included hypertension.

On December 15, 2021, at approximately 9:15 a.m. unlicensed personnel (ULP)-D was observed assisting R3 with bathing, dressing, grooming, bed mobility, transfers, standby assistance with ambulation with a walker, and medication administration.

R3's record lacked evidence of completed daily monitoring for temperature, pulse oximetry levels and COVID-19 symptom screening on November 30, 2021, and December 5, 10, 12, 13, and 14, 2021.

R6
R6's diagnoses included cardiomyopathy.

On December 15, 2021, at approximately 7:11 a.m. ULP-D was observed assisting R6 with medication administration.

R6's record lacked evidence of completed daily monitoring for temperature, pulse oximetry levels and COVID-19 symptom screening on December

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0 510	Continued From page 7 5, 10, 12, 13, and 14, 2021. On December 15, 2021, at approximately 1:00 p.m. interim clinical director (ICD)-B confirmed R3 and R6 were not screened for COVID-19 at least daily as recommended. The licensee's COVID-19 Plan dated August 31, 2021, indicated all residents are screened for fever and respiratory systems at least daily. DISINFECTING EQUIPMENT On December 15, 2021, at approximately 9:00 a.m. ULP-D was observed walking down the hallway caring a blood pressure machine. ULP-D stated she had performed blood pressure monitoring on a resident. ULP-D put the blood pressure machine on a bench in the hallway on the first floor. ULP-D used hand sanitizer before entering apartment 107. ULP-D came out of apartment 107, picked up the blood pressure machine, and proceeded to apartment 102 to check that resident's blood pressure. Prior to entering apartment 102, ULP-D was questioned regarding disinfecting of the blood pressure machine. ULP-D stated she had not cleaned the blood pressure machine between residents because ULP-D placed the blood pressure cuff over the resident's clothing, and the blood pressure cuff does not touch the resident's skin. On December 15, 2021, at approximately 1:00 p.m. ICD-B stated the blood pressure machine should be disinfected between residents. The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated July 24, 2021, indicated reusable equipment will be	0 510		

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0 510	Continued From page 8 properly cleaned and disinfected after use. EYE PROTECTION The MDH guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids, dated December 7, 2021, indicated health care workers working with residents without suspected or confirmed SARS-CoV-2 wear eye protection and facemasks in communities with moderate and high community transmission levels. The Centers for Disease Control and Prevention (CDC) guidance titled, Strategies for Optimizing the Supply of Eye Protection updated September 13, 2021, indicated healthcare personnel (HCP) working in areas of high substantial transmission should use eye protection during all resident encounters. On December 15, 2021, at approximately 7:15 a.m. ULP-G was observed walking out of R1's apartment wearing her protective eyewear on top of her head. ULP-G confirmed her eye protection should be worn over her eyes. On December 15, 2021, at approximately 7:15 a.m. ULP-H was observed wearing only eyeglasses. ULP-H stated, "I wear glasses. This is my eye protection." The licensee's undated policy titled, COVID-19 Plan, indicated the licensee followed current CDC and MDH guidelines for PPE. HAND HYGIENE On December 15, 2021, at approximately 8:25 a.m. ULP-G was observed removing her gloves	0 510		

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0 510	Continued From page 9 after administering R1's medications. ULP-G did not perform hand hygiene after glove removal. The licensee's undated policy titled, Hand Hygiene, indicated hand hygiene should be performed immediately after removing gloves. No further information was provided. TIME PERIOD TO CORRECT: Two (2) days.	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in ongoing quality management activities relevant to the size and services provided by the assisted living and to maintain documentation of those quality management activities. This had the potential to affect all 53 residents receiving assisted living services, staff and visitors.	0 580		

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0 580	Continued From page 10 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: On December 14, 2021, at approximately 9:00 a.m. during the entrance conference with licensed assisted living director (LALD)-A, the surveyor requested to review documentation of the licensee's quality management activities. LALD-A confirmed the licensee had not formalized or documented ongoing quality management activities relevant to the size and services provided by the assisted living. The licensee's Quality Management Plan policy dated July 17, 2021, indicated the assisted living director will develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement effort consistent with current professional standards and the highest quality services for residents. The minutes of the Quality Council Meeting will be retained for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 630		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES III ASSISTED LIVING	50 EAST ST. MARIE STREET DULUTH, MN 55803

(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
0 630	Continued From page 11 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed for one of one resident (R4) receiving housing only and failed to ensure development of an individual abuse prevention plan with the required content for four of four residents (R3, R1, R2, R7) receiving assisted living services 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, 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: R4 Review of the resident roster dated December 14, 2021, indicated R4 started receiving services on	0 630		

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0 630	Continued From page 12 August 27, 2019. The same roster identified R4 as "Housing Only No Services." On December 14, 2021, at approximately 2:00 p.m. the surveyor requested an IAPP for R4. On December 14, 2021, at approximately 2:55 p.m. interim clinical director (ICD)-B stated an IAPP had not been developed for R4, or any of the residents receiving "Housing Only No Services". On December 15, 2021, at approximately 10:30 a.m. R4 stated she moved in 2019. R4 stated she is not receiving any services other than meals from the facility. R3 R3's record lacked an IAPP that included the resident's risk for falls, and required content. R3's diagnoses included hypertension. Resident notes and Incident Reports revealed resident R3 had seven (7) falls between August 8, 2021, and November 23, 2021. The Fall Risk Assessment dated November 16, 2021, indicated R3 was a high risk for falls. R3's Service Plan dated December 1, 2021, indicated R3 required assistance with medication administration, bathing, grooming, dressing, toileting, transfers, bed mobility, stand by assistance, cuing with ambulation with a walker, and two-hour safety checks. R3's Service Plan indicated R3 was vulnerable in the following areas: financial management, can not report abuse, elopement risk, inconsistent communication, memory impairment, resistive to cares, and difficulty using call system. On December 15, 2021, at approximately 9:15 a.m. unlicensed personnel (ULP)-D was observed assisting R3 with bathing, dressing, grooming, bed mobility, transfers, stand by assistance with ambulation with a walker, and medication	0 630		

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0 630	Continued From page 13 administration. On December 15, 2021, at approximately 2:20 p.m. ICD-B stated R3's IAPP was included in the resident's service plan; however, R3's Service Plan did not include R3's risk for falls, the person's susceptibility to abuse by another individual, the person's risk of abusing other vulnerable adults, and the person's risk of self-abuse. ICD-B confirmed R3's individual abuse prevention plan did not include R3's risk for falls, the susceptibility of abuse by another individual, the risk of abusing other vulnerable adults, and the risk of self-abuse. R1 R1's service plan dated December 1, 2021, indicated R1 required staff assistance with medication management, weekly maintenance for her four-wheeled walker, standby assistance with dressing, nurse case management, housekeeping, laundry services, and blood glucose checks four times per day. R1's service plan indicated R1 was vulnerable due to chronic conditions and poor endurance and strength. R1 walked using a four-wheeled walker. R1's assisted living (AL) assessment dated November 24, 2021, indicated R1 was assessed in the following areas: medical history and wellness overview, body systems, nutrition and hydration, recreational drugs and alcohol, smoking, infectious disease, COVID-19 status, functional capabilities, cognitive capabilities (mental health, self-preservation, psychosocial support), safety and evacuation, leisure time and activities, communication with others, cultural affiliations, housekeeping, laundry, bed making, and other ancillary services, medication management, injectable medications, diabetes	0 630		

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0 630	Continued From page 14 mellitus, anticoagulation therapy, physician-ordered labs, other medical needs, pain evaluation, and home health and hospice. R1's record lacked an IAPP. R2 R2's service plan dated November 30, 2021, indicated R2 required staff assistance with medication management, stand-by assistance with ambulation, bathing, activity reminders, escorts to the dining room, daily safety checks, reorientation to environment, nurse case management, weekly maintenance on her four-wheeled walker, emergency evacuation, housekeeping, laundry, and daily vital signs including daily Covid-19 screening. R2 walked using a four wheeled walker. R2's service plan indicated R2 was vulnerable to dependence on others for financial management and short-term memory impairment. R2's AL assessment dated December 9, 2021, indicated R2 was assessed in the following areas: medical history and wellness overview, body systems, nutrition and hydration, recreational drugs and alcohol, smoking, infectious disease, COVID-19 status, functional capabilities, cognitive capabilities (mental health, self-preservation, psychosocial support), safety and evacuation, leisure time and activities, communication with others, cultural affiliations, housekeeping, laundry, bed making, and other ancillary services, medication management, injectable medications, diabetes mellitus, anticoagulation therapy, physician-ordered labs, other medical needs, pain evaluation, and home health and hospice. R2's record lacked an IAPP.	0 630		

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0 630	Continued From page 15 R7 R7's service plan dated December 15, 2021, indicated R7 required staff assistance with medication management, daily blood pressure monitoring, nurse case management, housekeeping, laundry, and emergency evacuation. R7's service plan indicated R7 was vulnerable to financial management due to her dependence on others for financial management. R7's AL assessment dated November 18, 2021, indicated R7 was assessed in the following areas: medical history and wellness overview, body systems, nutrition and hydration, recreational drugs and alcohol, smoking, infectious disease, COVID-19 status, functional capabilities, cognitive capabilities (mental health, self-preservation, psychosocial support), safety and evacuation, leisure time and activities, communication with others, cultural affiliations, housekeeping, laundry, bed making, and other ancillary services, medication management, injectable medications, diabetes mellitus, anticoagulation therapy, physician-ordered labs, other medical needs, pain evaluation, and home health and hospice. R7's record lacked an IAPP. On December 15, 2021, at approximately 2:20 p.m. ICD-B stated resident vulnerable adult assessments were embedded in the assisted living nursing assessment. ICD-B stated, "once you lock in the nursing assessment, it will bring you back to the service plan. The service plan addresses their vulnerabilities." The licensee's Individual Abuse Prevention Plan policy dated July 17, 2021, indicated an individual	0 630		

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0 630	Continued From page 16 abuse prevention plan is developed for each assisted living resident. the individual abuse prevention plan will include: individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults, the resident's risk of abusing other vulnerable adults, specific measures to minimize the risk of abuse to that person and other vulnerable adults, and measures to minimize the risk of self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	0 650		

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0 650	Continued From page 17 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content for one of three employees (interim clinical director(ICD)-B) with employee 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ICD-B was hired the beginning of November 2021, to provide supervisory services for the licensee. ICD-B employee recorded lacked a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. On December 16, 2021, at approximately, 3:55 p.m. licensed assisted living director (LALD)-A confirmed ICD-B's employee record did not contain a current job description.	0 650		

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0 650	Continued From page 18 The licensee's "Personnel Records" policy dated July 27, 2021, indicated the personnel record would include a current job description, which includes qualifications, responsibilities and identification of supervisors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 19 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to conduct evacuation drills. This had the potential to affect all 53 residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 16, 2021, at 1:30 p.m. records were provided for review by licensed assisted living director (LALD)-A. On December 16, 2021, between 1:30 p.m. and 2:00 p.m. records were reviewed by survey staff. Evacuation drill logs were not included. On December 16, 2021, at approximately 2:20 p.m. LALD-A confirmed during the exit interview, that the licensee failed to conduct evacuation drills between August 1, 2021, and December 16, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 950 SS=F	144.50 Subd. 3 Designation of representative (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: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. 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." (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 name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for five of five residents (R3, R4, R1, R2, and R7) with records reviewed. This had the potential to	0 950		

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0 950	Continued From page 21 affect al 53 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3 R3's service plan dated December 1, 2021, indicated the resident received services which included medication administration, assistance with bathing, dressing, grooming, toileting, transferring, and stand by assistance with ambulation. R3's Resident Contract dated December 1, 2021, page 14, included an area titled, "Right to Designate a Representative for Certain Purposes," indicating R3 had the right to name a designated representative. R3 did not indicate whether or not they wanted to name a Designated Representative. R4 The Resident Roster provided upon entrance on December 17, 2021, indicated R4 only received housing and did not receive assisting living services. R4's Resident Contract dated December 6, 2021, page 14, included an area titled, "Right to Designate a Representative for Certain Purposes," indicating R4 had the right to name a designated representative. R4 did not indicate	0 950		

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0 950	Continued From page 22 whether or not they wanted to name a Designated Representative. On December 14, 2021, at approximately 2:55 p.m. licensed assisted living director (LALD)-A confirmed R3 and R4's Resident Contract did not indicate whether or not the resident wanted to name a Designated Representative. R1 R1's service plan dated December 1, 2021, indicated R1 required staff assistance with medication management, weekly maintenance for her four-wheeled walker, standby assistance with dressing, nurse case management, housekeeping, laundry services, and blood glucose checks four times per day. R1's service plan indicated R1 was vulnerable due to chronic conditions and poor endurance and strength. R1's Resident Contract dated December 1, 2021, page 14, included an area titled, "Right to Designate a Representative for Certain Purposes," indicating R1 had the right to name a designated representative. R1's resident contract lacked required signatures from R1 and a designated representative to indicate R1 was asked to designate a representative. R2 R2's service plan dated November 30, 2021, indicated R2 required staff assistance with medication management, stand-by assistance with ambulation, bathing, activity reminders, escorts to the dining room, daily safety checks, reorientation to environment, nurse case management, weekly maintenance on her	0 950		

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0 950	Continued From page 23 four-wheeled walker, emergency evacuation, housekeeping, laundry, and daily vital signs including daily Covid-19 screening. R2 walked using a four wheeled walker. R2's Resident Contract dated December 1, 2021, page 14, included an area titled, "Right to Designate a Representative for Certain Purposes," indicating R2 had the right to name a designated representative. R2's resident contract lacked required signatures from R2 and a designated representative to indicate R2 was asked to designate a representative. R7 R7's service plan dated December 15, 2021, indicated R7 required staff assistance with medication management, daily blood pressure monitoring, nurse case management, housekeeping, laundry, and emergency evacuation. R7's Resident Contract dated December 1, 2021, page 14, included an area titled, "Right to Designate a Representative for Certain Purposes," indicating R1 had the right to name a designated representative. R7's resident contract lacked required signatures from R7 and a designated representative to indicate R7 was asked to designate a representative. On December 14, 2021, at approximately 9:10 a.m. LALD-A and interim clinical director (ICD)-B stated they were both familiar with assisted living laws and regulations.	0 950		

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0 950	Continued From page 24 A policy was requested, but not provided. No further information was provided. TIME PERIOD TO CORRECT: Twenty-One (21) Days.	0 950		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (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; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (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	01470		

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01470	Continued From page 25	01470		

other relevant advocacy services; and
(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.
(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:
(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;
(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for two of three employees (unlicensed personnel (ULP)-D, and ULP-G) 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, but was not likely to cause serious injury, impairment, or death), and

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01470	Continued From page 26 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D started employment on March 7, 2014, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On December 15, 2021, at approximately 9:15 a.m. ULP-D assisted R3 with medication administration, bathing, dressing, grooming, bed mobility, transfers, and stand by assistance with ambulation. ULP-D's employee record lacked evidence ULP-D had completed the following components of orientation: - an overview of the 144G statutes; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-G started employment on June 17, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On December 15, 2021, at approximately 8:15 a.m. ULP-G assisted R7 with medication administration, blood sugar checks, safety checks, and assistance with transferring in bed. ULP-G's employee record lacked evidence ULP-G completed the following components of orientation: - an overview of the statutes;	01470		

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01470	Continued From page 27 - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On December 17, 2021, at approximately 8:00 a.m. licensed assisted living director (LALD)-A confirmed ULP-D and ULP-G had not completed all components of orientation as indicated above. The licensee's Assisted Living and Assisted Living with Dementia Care - All Staff policy dated July 17, 2021, indicated at a minimum, orientation must include the following topics: an overview of this chapter; the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not	01540		

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01540	Continued From page 28 provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three direct-care employees (unlicensed personnel (ULP)-D) completed at least eight hours of initial dementia training 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D started employment on March 7, 2014, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On December 15, 2021, at approximately 9:15 a.m. ULP-D assisted R3 with medication administration, bathing, dressing, grooming, bed mobility, transfers, and stand by assistance with ambulation.	01540		

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01540	Continued From page 29 ULP-D's employee record indicated ULP-D had only completed five hours of dementia training. On December 17, 2021, at approximately 8:00 a.m. licensed assisted living director (LALD)-A confirmed ULP-D had not completed at least eight hours of dementia training as required. The licensee's Dementia Training Disclosure, undated, indicated direct-care team members receive at least eight hours of dementia training. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
01620 SS=G	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an 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	01620		

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01620	Continued From page 30 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) assessed one of one resident (R3) with falls for causative factors to determine individualized interventions to reduce the resident's risk for injury with records reviewed. This resulted in an immediate correction order on December 16, 2021. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: R3's diagnoses included diabetes, hypertension, and depression. The Fall Risk Assessment dated November 16, 2021, indicated R3 was a high risk for falls. The Nursing Assessment dated November 16, 2021, indicated R3 was oriented to person, short- and long-term memory impairment, and unable to give accurate information consistently. R3 requires physical assistance with bathing, grooming, dressing, transfers, bed mobility, and cueing and stand by assistance with ambulation using a walker.	01620		

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01620	Continued From page 31 The BIMS (Brief Interview for Mental Status) dated November 16, 2021, indicated R3 was severely cognitively impaired. Resident notes and Incident Reports revealed resident R3 had seven (7) falls between August 8, 2021, and November 23, 2021. R3's record lack evidence a re-evaluation had been completed by a registered nurse (RN) to assess for causative factors to determine individualized interventions to reduce the resident's risk for injury. Incident Reports and Resident notes revealed the following: -August 4, 2021, at 10:08 a.m. resident note (written by a licensed practical nurse/LPN) indicated R3 "had episodes of increased confusion and exit seeking. Wandering around the building and riding the elevator over the weekend." -August 5, 2021, at 12:53 p.m. resident note: [R3] returned from clinic. The physician return comments after the appointment indicated "Patient has profound hearing loss which compounds and complicates diagnoses". -Incident Report dated August 8, 2021, at 8:05 p.m. indicated R3 had a fall in her kitchen, throwing garbage away. R3 did not use her pendant to call for help. R3 had four bruised areas and a tiny scrape. -August 9, 2021, at 9:27 a.m. resident note (written by a LPN) indicated R3 "fell in kitchen last evening, resident did not use pendant however called for help and staff responded. Walker was near her. Able to move all extremities and up with	01620		

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walker today. Resident has a bruise on right eyelid, chin and on her left knee."

-Incident Report dated August 15, 2021, at 7:30 a.m. indicated staff went to deliver breakfast and found R3 on the floor in front of her recliner in the living room. R3's walker was in the bedroom. R3 stated she fell out of bed and scooted to the living room. R3 had bruises on lower legs.

-August 15, 2021, at 8:21 a.m. resident note (written by a LPN) indicated R3 was "found on the floor in the living room in front of her recliner. She stated she 'fell out of bed and scooted across the bedroom floor to living room.'" R3 had a "bruise on the right hip and now has bruises on both knees. Resident reminded to use her pendant to call for assistance and to use her walker whenever she is ambulating in her apartment as well as in the hallways. Staff continue to do frequent safety checks and reminders."

-August 17, 2021, at 6:36 p.m. resident note indicated R3 was "found by another resident at 5:40 p.m. outside the "G" level door and trying to get back in the building."

-September 2, 2021, at 8:05 a.m. resident note (written by a LPN) indicated "left message" with R3's daughter "regarding fall earlier this a.m. Resident is up in her apartment and able to ambulate per usual status and denies discomfort. Dressing applied by EMT [emergency medical technician] is intact on right lower leg."

-Incident Report dated October 4, 2021, at 3:50 p.m. indicated R3 fell in her bedroom, in front of bathroom entry way. R3's walker was close by. R3 was unable to explain how she fell, but said she was on her way to bathroom. R3 called using

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01620	Continued From page 33 her pendant. -October 5, 2021, at 10:05 a.m. resident note (written by a LPN) indicated R3 "used her pendant to call evening staff at 1600 yesterday and had fallen in the doorway of her bathroom. Able to move all extremities. VSS [Vital signs stable]. Assisted to standing position with two assistants. No apparent injury and able to ambulate per usual." -October 11, 2021, at 8:30 a.m. resident note (written by a LPN) indicated "weekend staff reported confusion and sun downing continues, is awake often late into the night, finally going to bed at 3:10 a.m. on 10/9/2021. Additionally, she had a fall the previous week which did not result in any injury." -Incident Report dated October 15, 2021, at 11:00 a.m. indicated R3 fell in the bathroom from toilet. R3's walker was close by. R3 hit head on wall of bathroom and complains of pain. No open areas noted. R3 complained of right hip pain and fear of moving. -October 15, 2021, at 11:39 a.m. resident note (written by a LPN) indicated R3 was "found on the floor in her bathroom when staff went to escort her to the dining room for lunch. She was self transferring off the toilet and appears to have lost her balance. Resident is laying on the floor next to the toilet with her head against the wall and complains of her head and right hip being painful. No open wounds on the back of her head, cuts or abrasions." R3 was transported to the emergency room for evaluation. At 8:36 p.m. R3 was "transported back to facility. No fractures or neuro issues from fall earlier today."	01620		

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01620	Continued From page 34 -October 18, 2021, at 10:22 a.m. resident note (written by a LPN) indicated R3 still maintained "some slight pain in left knee upon standing however this dissipates with movement. Her left knee is slightly swollen and lightly reddened. She ambulates at her base line and does not display any impeded movement from knee injury." -November 11, 2021, at 10:14 a.m. resident note fall follow up nurses note indicated R3 was "assessed for post fall, is eating breakfast at this time, denies pain, reminded to use call light for safety issues, will continue to monitor." -November 16, 2021, at 5:28 p.m. resident note indicated spoke with R3's daughter regarding concerns and safety. -Incident Report dated November 23, 2021, at 2:00 p.m. indicated R3 fell in living room near her dresser. R3 stated she was walking in her living room for her check book and lost her balance. -November 23, 2021, at 2:26 p.m. resident note indicated writer was called to R3's apartment, "staff stated they found her on the floor, writer found her sitting on floor next to her hutch, stated she was trying to get over to the TV (television)." R3 indicated she had pain rated a five (5) out of ten (10) in right hip. R3 had "complete range of motion to right hip and leg. Staff assisted R3 up with walker and she walked back to her recliner." Physician notified. -December 2, 2021, at 3:54 p.m. resident note indicated a care conference was held with R3's family. Discussed a decline in cognition and safety. Discussed falls and possible need to move out. Staff will also not escort to and from meals and activities.	01620		

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R3's Service Plan dated December 1, 2021, indicated R3 required assistance with medication administration, bathing, grooming, dressing, toileting, transfers, bed mobility, stand by assistance, cuing with ambulation with a walker, and two-hour safety checks. R3's Service Plan did not address interventions to prevent the risk of falls.

R3's record lacked evidence a re-evaluation had been completed by a RN to assess for causative factors to determine individualized interventions to reduce the resident's risk for injury. In addition, R3's record lacked evidence a plan had been put into place on how to keep R3 safe until the possible discharge to another facility.

On December 15, 2021, at approximately 9:15 a.m. unlicensed personnel (ULP)-D assisted R3 with getting out of bed, walking to the bathroom with walker, toileting, bathing, dressing, grooming. ULP-D walked with R3 to the dining room table for breakfast. ULP-D warmed up R3's breakfast and administered R3's morning medications.

On December 15, 2021, at approximately 3:00 p.m. interim clinical director (ICD)-B confirmed the RN had not completed re-evaluation to assess R3 for causative factors to determine individualized interventions to reduce R3's risk for injury. ICD-B stated a care conference with family had been held and R3's family is looking into moving R3 to a memory care facility. ICD-B confirmed a plan had not been developed to keep R3 safe until the move.

On December 16, 2021, at approximately 12:15

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01620	Continued From page 36 p.m. ICD-B confirmed R3 required physical assistance with toileting. On December 16, 2021, at approximately 11:58 a.m. licensed assisted living director (LALD)-A stated they did not have a specific fall policy. LALD-A provided the licensee's Reporting, Documenting and Reviewing Incidents Involving Residents policy dated July 17, 2021, which LALD-A stated they follow for all incidents. The policy indicated: staff discovering an incident involving a resident will ensure the resident is safe; the nurse is notified; staff complete an incident report; the nurse will complete an assessment of the resident in a timeframe that is reasonable following the incident; the nurse will document in the resident's chart the details of any incident involving the resident and their assessment including follow-up actions that were taken; the physician, resident representative, and the clinical nurse supervisor will be notified of the incident and notification will be documented; and the LALD or clinical nurse supervisor will review the incident report with the quality management team and document the review. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed on December 17, 2021, however noncompliance remains at a scope and severity of D. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01690	Continued From page 37	01690		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow their written	01690		

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01690	Continued From page 38 policy pertaining to the counting of controlled medications for one of seven residents (R1) 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 14, 2021, at 9:10 a.m. interim clinical director (ICD)-B stated there were no narcotics in the facility. R1's medical record indicated the resident was admitted on November 19, 2019, with diagnoses including, but were not limited to, diabetes, diabetic polyneuropathy, and chronic kidney disease stage 3. R1's service plan dated December 1, 2021, indicated R1 received medication management services. R1's medication administration record (MAR) dated December 2021, indicated R1 was prescribed the following controlled substances: hydromorphone hydrochloride (HCL), 2 milligram (mg) tablets. Take 0.5 tablet, 1 mg by mouth (PO), every hour as needed (PRN) for moderate to severe pain, (4-10/10 on a pain scale), or shortness of breath (SOB). Okay to crush. Maximum one dose every hour. Code to lock box [XXX]. Analgesic-opioid, drug schedule: 2; lorazepam, 0.5 mg tablets. Take 0.5 mg tablet PO	01690		

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every four hours PRN for anxiety; a ½ tablet (0.25 mg) may be taken PO or sublingual. Okay to crush. Maximum one dose every four hours. Code for lock box [xxxx].

Review of R1's December 2021, MAR indicated R1 was not administered any lorazepam in December 2021.

Review of R1's December 2021, MAR indicated R1 received 1 mg hydromorphone tablets on the following December 2021 dates:

*December 11 at 3:24 a.m.
*December 12 at 12:10 p.m.
*December 13 at 12:05 p.m.
*December 14 at 3:24 a.m., 2:10 p.m., 5:49 p.m., 9:34 p.m.

On December 14, 2021, at 12:40 p.m. the surveyor observed a hand-written communication note written by unlicensed personnel (ULP)-H. The communication note indicated on December 13, 2021, at 3:25 a.m. ULP-H administered hydromorphone HCL 1 mg PO to R1. The communication note indicated on December 13, 2021, at 5:15 a.m. another dose of hydromorphone 1 mg PO was administered to R1. On the communication note, ULP-H documented the following: 3:25 a.m.-R1 asked for a pain pill. I had trouble finding the PRN section, but finally found it. I gave R1 the ½ pill of hydromorphone and I signed and initialed for it on the sheets. I recorded it on the computer but am not sure that it synced properly. I tried several times to sync it before logging out but I'm not sure if it worked. I tired. 5:15 a.m.-R1 asked for another hydromorphone. I double checked with the licensed practical nurse (LPN)-C first to make sure it was okay. I tried and tried to record it on

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the computer, but I couldn't make it work. But the computer says I gave her something for loose bowel movements, which I did not. Help! To clarify, R1 received ½ hydromorphone at 3:25 a.m.

On December 14, 2021, at 2:55 p.m. the surveyor asked ICD-B about R1's prescribed 1 mg hydromorphone HCL. ICD-B stated, "oh, it's (hydromorphone), kept in a locked cabinet inside a locked metal box inside her apartment."

On December 14, 2021, at 3:37 p.m. the surveyor entered R1's apartment with ICD-B. Above R1's stove was a locked cabinet where R1's medications were stored. Inside the cabinet were a small, plastic bin containing blister packaged medications, and a rectangular, locked metal box. Inside the locked metal box was R1's 1 mg hydromorphone, packaged in a blister pack, and a narcotic count sheet for direct care staff to record the removal and administration of the narcotic. The narcotic count sheet listed the following columns: date, prescription number, drug name and strength, drug count, amount set-up, amount left, and nurse (direct care staff) signature. The surveyor did not see R1's 0.5 mg of lorazepam or its count sheet inside the metal lock box.

Review of R1's December 2021, narcotic count sheet indicated the following recorded narcotic counts and administrations of hydromorphone:

*December 3, (no time): drug count-30; amount set-up-took out one; amount left-29; registered nurse (RN) and licensed practical nurse (LPN) signatures.

*December 3, at 9:00 a.m.: Resident refused Dilaudid (hydromorphone), 1 mg tablet. RN

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01690	Continued From page 41 signature. *December 11, at 9:00 a.m.: hydromorphone 2 mg; drug count-29; amount set-up-1/2 tablet; amount left-28; LPN signature. *December 12 (no time): drug count 28; amount set-up-1/2 tablet; amount left-27; no signature. *December 13 (no time): drug count-27; amount set-up-1/2 tablet; amount left-27; direct care staff initials. *December 14, at 3:25 a.m.: drug count-26; amount set-up-1/2 tablet; amount left-26; initials *December 14, at 5:15 a.m.: drug count-25; amount set-up-1/2 tablet; amount left-25; initials. A review of R1's December 2021, narcotic count sheet and hydromorphone blister pack indicated six hydromorphone were recorded on the narcotic sheet, but eight hydromorphone were removed from the blister pack. On December 14, 2021, at 3:50 p.m. ICD-B stated outgoing and incoming direct care staff were not performing R1's narcotic count before and after each shift. On December 14, 2021, at 3:50 p.m. the surveyor found R1's lorazepam stored inside a small plastic bin next to the locked metal box. The lorazepam was stored with R1's non-controlled medications and did not have a controlled substance count sheet for counting R1's lorazepam before and after each shift. On December 14, 2021, at 4:28 p.m. LPN-C stated she and ICD-B reconciled the narcotic count for R1's hydromorphone. LPN-C stated ULP-H administered the two hydromorphone to R1 but was unable to electronically chart the administration of the narcotic.	01690		

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01690	Continued From page 42 On December 14, 2021, at 4:30 p.m. ICD-B stated she immediately implemented training to educate direct care staff on performing a narcotic count during each shift, and informed the nurses if they were unable to chart electronically. In addition, ICD-B stated she created a new resident narcotic log sheet, adding additional columns for recording time, nurse signature, recording the administration, and date and time for verifying the count. On December 15, 2021, at 7:15 a.m. ULP-G stated, "we didn't have a process before." The licensee policy titled, Controlled Substances/Schedule II Drugs dated July 24, 2021, indicated staff persons coming on duty and staff persons going off duty would count controlled medications together and would document and report any discrepancies immediately to the registered nurse (RN). No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01690		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by:	01710		

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01710	Continued From page 43 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment of a resident's medication management services after medication changes for one of one resident (R1)with record 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: R1's medical record indicated the resident was admitted on November 19, 2019, with diagnoses including, but were not limited to, diabetes, diabetic polyneuropathy, and chronic kidney disease stage 3. R1's service plan dated December 1, 2021, indicated R1 required staff assistance with medication management, weekly maintenance for her four-wheeled walker, standby assistance with dressing, nurse case management, housekeeping, laundry services, and blood glucose checks four times per day. R1's service plan indicated R1 was vulnerable due to chronic conditions and poor endurance and strength. R1 walked using a four-wheeled walker. R1's hospital discharge summary dated November 24, 2021, at 11:29 a.m. indicated R1 was hospitalized from November 16, 2021, through November 24, 2021. Included in R1's	01710		

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discharge summary was information on discontinued medications and new medication information. R1's new medications included: aspirin (thins blood) 81 milligrams (mg) chewable; once per day with food (start date: November 24, 2021); gabapentin (used for nerve pain) 300 mg, one capsule by mouth (PO), two times per day (start date: November 24, 2021); metoprolol (treats high blood pressure) 25 mg, take 0.5 tablet (12.5 mg), PO two times per day (start date: November 24, 2021); nitroglycerin, place one tablet under tongue every five minutes as needed (PRN) for chest pain (start date: November 24, 2021); lorazepam 0.5 mg tablet, PO every four hours PRN for anxiety. May take 0.25 mg PO or sublingual. Maximum one dose every four hours (start date: November 29, 2021); hydromorphone hydrochloride (HCL), 2 mg tablets. Take 0.5 tablet (1 mg) PO every hour PRN for moderate to severe pain (4-10/10 pain scale), or shortness of breath (SOB) (start date: December 1, 2021).

On December 15, 2021, at 3:15 p.m. interim clinical director (ICD)-B stated she did not perform a medication assessment on R1 after R1 was prescribed new medications following her discharge from the hospital.

The licensee policy titled, Initial and On-Going Nursing Assessment of Residents dated July 25, 2021, indicated
the RN reassessed each resident on an on-going basis. The RN reassessed residents if the resident had a change-in-condition. Reassessment included: (i) review of the resident's service plan; (ii) evaluation of the resident's medication management services and medications; (iv) communicate new problems or concerns to the resident's physician or health

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01710	Continued From page 45 care providers; (v) update the service plan as necessary based on resident's needs. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01710		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to	01730		

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01730	Continued From page 46 documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure individual medication management plans were followed and/or failed to ensure individual medication management plans contained all the required content for four of four residents (R6, R1, R2, and R7) 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, 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: During the entrance conference on December 14, 2021, at approximately 9:00 a.m. interim clinical manager (ICM)-B confirmed the licensee provided medication management services to several of the residents.	01730		

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01730	Continued From page 47 R6 R6's record lacked evidence R6's individualized medication management plan was followed and the individualized medication management plan included all components. R6's service plan dated December 1, 2021, indicated R6 received assistance with medication administration. R6's prescriber's orders dated December 6, 2021, included the following medications: one medication to treat heart burn, one medication to treat congestive heart failure, one medication to treat atrial fibrillation (irregular, often rapids heart rate), and potassium replacement. On December 15, 2021, at approximately 7:11 a.m. unlicensed personnel (ULP)-D was observed to place one oral medication into a medication cup and set the medication cup on the stove in R6's kitchen. R6 was not in the resident apartment at that time, but was in the dining room eating breakfast. ULP-D left R6's apartment. ULP-D stated R6 would take the medication when R6 returned to the apartment. R6's AL Nursing Assessment dated November 15, 2021, section 6, Medication Management indicated R6 required assistance with medication administration. R6's record lacked evidence an individualized medication management plan had been developed to include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and	01730		

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01730	Continued From page 48 - procedures for staff mortifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. R1 R1's medical record indicated the resident was admitted on November 19, 2019, with diagnoses including diabetes, diabetic polyneuropathy, and chronic kidney disease stage 3. R1's service plan dated December 1, 2021, indicated R1 received medication management services. R1's assisted living (AL) nursing assessment dated November 24, 2021, page 11, Section 6, Medication Management, indicated R1 required assistance with medication administration. R1's record lacked evidence an individualized medication management plan was developed to include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff mortifying a registered nurse or appropriate licensed health professional when a problem arises with medication	01730		

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01730	Continued From page 49 management services. R2 R2's medical record indicated the resident was admitted on November 30, 2021, with diagnoses including unspecified severe protein calorie malnutrition, adult failure to thrive, and moderate capsular glaucoma of the left eye. R2's service plan dated November 30, 2021, indicated R2 received medication management services. R2's AL nursing assessment dated November 30, 2021, page 11, Section 6, Medication Management, indicated R2 required assistance with medication administration. R2's record lacked evidence an individualized medication management plan was developed to include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff mortifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services.	01730		

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01730	Continued From page 50 R7 R7's medical record dated December 15, 2021, indicated the resident was admitted on February 2, 2018, with diagnoses including hypertension and anxiety. R7's service plan dated December 15, 2021, indicated R7 received medication management services. R7's AL assessment dated November 18, 2021, page 11, Section 6, Medication Management, indicated R7 required assistance with medication administration. R7's record lacked evidence an individualized medication management plan was developed to include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff mortifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On December 15, 2021, at 7:15 a.m. ULP-G was observed placing one aspirin, one calcium tablet, one antidepressant, two high blood pressure pills,	01730		

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01730	Continued From page 51 two tablets to prevent chest pain, and one Tylenol inside a medication cup. ULP-G left the medication cup containing the medications on R7's kitchen counter. ULP-G stated, "R7 brings her medications down to the dining room so she can eat them with her breakfast. After breakfast she comes back and mixes her Miralax." A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's recommendations for one of five residents (R1) 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, 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	01880		

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01880	Continued From page 52 situation has occurred only occasionally). The findings include: R1's medical record indicated the resident was admitted on November 19, 2019, with diagnoses including diabetes, diabetic polyneuropathy, and chronic kidney disease stage 3. R1's service plan dated December 1, 2021, indicated R1 received medication management services. Review of R1's medication administration record (MAR) dated December 2021, indicated R1 was prescribed the following controlled substance: lorazepam, 0.5 milligrams (mg) tablets. Take 0.5 mg tablet by mouth) PO every four hours as needed (PRN) for anxiety; a ½ tablet, (0.25 mg) may be taken PO or sublingual. Okay to crush. Maximum one dose every four hours. Code for lock box (XXX). On December 14, 2021, at 3:50 p.m. the surveyor found R1's lorazepam stored inside a small plastic bin next to the locked metal box. The lorazepam was stored with R1's non-controlled medications and did not have a controlled substance count sheet for counting R1's lorazepam before and after each shift. On December 14, 2021, at 3:55 p.m. interim clinical director (ICD)-B stated she was unaware R1's lorazepam was not double locked. The licensee policy titled, Controlled Substances dated July 24, 2021, indicated the registered nurse identified staff authorized to have access to controlled substances would set-up an appropriate system to control access and keys to	01880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES III ASSISTED LIVING	50 EAST ST. MARIE STREET DULUTH, MN 55803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 53 the compartments where controlled substances were stored. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20866	A. BUILDING: _____ B. WING _____	12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINES III ASSISTED LIVING	50 EAST ST. MARIE STREET DULUTH, MN 55803

(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
01940	Continued From page 54 changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a treatment management plan was developed for one of one resident (R1) receiving blood glucose monitoring 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's medical record indicated the resident was admitted on November 19, 2019, with diagnoses including diabetes, diabetic polyneuropathy, and chronic kidney disease stage 3. R1's service plan dated December 1, 2021, indicated R1 required staff assistance with blood glucose checks four times per day. R1's record failed to include evidence of a written individualized treatment or therapy management plan for blood glucose testing. On December 15, 2021, at 8:25 a.m. unlicensed personnel (ULP)-G was observed performing a blood glucose (sugar) test on R1. On December 15, 2021, at 3:15 p.m. interim	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20866	A. BUILDING: _____ B. WING _____	12/17/2021

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01940	Continued From page 55 clinical director (ICD)-B stated R1 did not have an individualized treatment plan for her daily blood sugar checks. The licensee policy titled Documentation of Medication, Treatment, and Therapy Management Services dated July 24, 2021, indicated the registered nurse (RN) would document the services the resident received on the resident's individualized medication management plan or individualized treatment and therapy plan, and the resident's medication/treatment record or medication administration record (MAR) or treatment administration record (TAR). No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20866	A. BUILDING: _____ B. WING _____	12/17/2021

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02040	Continued From page 56	02040		

licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. Mitigation of hazards to protect residents from harm was not included in the plan. This had the potential to affect all dementia care residents and staff.

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

On December 16, 2021, at 1:30 p.m. records were provided for review by licensed assisted living director (LALD)-A.

On December 16, 2021, between 1:30 p.m. and 2:00 p.m. records were reviewed by survey staff. The hazard vulnerability assessment within the Ecumen Emergency Plan dated August 10, 2021, did not identify hazards on and around the property. Additionally, the assessment did not include mitigation of hazards to protect residents from harm.

On December 16, 2021, at approximately 2:20 p.m. LALD-A confirmed during the exit interview that the licensee failed to identify hazards or safety risks on and around the property. LALD-A also confirmed that mitigation of hazards was not included in the hazard vulnerability assessment.

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/14/21*
Time: 10:00:00
Report: 1006211101

Food and Beverage Establishment Inspection Report

Location:
Pines Iii Assisted Living
50 East St. Marie Street
Duluth, MN55803
St. Louis County, 69

Establishment Info:
ID #: 0037689
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187245500
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

THE PERSON IN CHARGE WAS RECORDING IF THE STAFF WERE SICK ON THE SCHEDULES, BUT WAS NOT RECORDING SYMPTOMS. DISCUSSED RECORDING SYMPTOMS AND DAY/TIME OUT AND DAY/TIME RETURNED TO WORK, MDH LOG WAS LOCATED.

Corrected on Site

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

3-202.15 ** Priority 2 **

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

THERE WAS A BADLY DENTED CAN OF CREAM OF MUSHROOM SOUP IN DRY STORAGE. CAN WAS PULLED OUT AND PUT ASIDE FOR CREDIT. MAKE SURE ALL PACKAGING IS IN GOOD CONDITION.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT USES A QUAT SANITIZER, BUT DIDN'T HAVE ANY TEST STRIPS. PROVIDE QUAT TEST STRIPS TO ENSURE PROPER SANITIZING LEVELS OF 200-400 PPM ARE BEING MET AT ALL TIMES.

Type: Full
Date: *12/14/21*
Time: 10:00:00
Report: 1006211101
Pines Iii Assisted Living

Food and Beverage Establishment Inspection Report

Comply By: 01/01/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANITIZER DISPENSER
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANITIZER BOTTLE
Violation Issued: No

Hot Water: = at 175F Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Beverage Dispenser
Temperature: 37 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Cooking
Temperature: 168 Degrees Fahrenheit - Location: BEEF GOULASH
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: CABBAGE ROLL FILLING
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: CHEDDAR CHEESE
Violation Issued: No

Process/Item: Cooling
Temperature: 58 Degrees Fahrenheit - Location: FRUIT SALAD DESSERT
Violation Issued: No

Process/Item: Ice Cream Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN- BLUE BUNNY
Violation Issued: No

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

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

COMMENTS:

INSPECTION ACCOMPANIED BY FOOD SERVICES DIRECTOR, SARAH EVANS. THIS INSPECTION REPORT IS FOR THE LARGER FULL USE KITCHEN IN THE ASSISTED LIVING BUILDING.

Food and Beverage Establishment Inspection Report

KITCHEN IS CLEAN AND ORDERLY.

OBSERVED GOOD HAND WASHING AND GLOVE USE THROUGHOUT THE INSPECTION. DISCUSSED THE IMPORTANCE OF EXCLUDING BARE HAND CONTACT WITH ALL READY TO EAT FOODS BY USING GLOVES, TONGS, DELI TISSUE, ETC. DISCUSSED THE IMPORTANCE OF PROPER AND FREQUENT HAND WASHING.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH HEPATITIS A., E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS.

DISCUSSED RAW SHELL EGGS VS. PASTERUIZED EGGS REQUIREMENT. FACT SHEET LEFT WITH STAFF.

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 1006211101 of 12/14/21.

Certified Food Protection Manager: Sarah I Evans

Certification Number: FM4495 Expires: 09/25/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Sarah Evans
Food Services Director

Signed: _____
Inspector 1006

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