Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 11, 2023

Licensee
Northwoods Villa Inc
1212 Gunn Road
Grand Rapids, MN 55744

RE: Project Number(s) SL37388015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 3, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

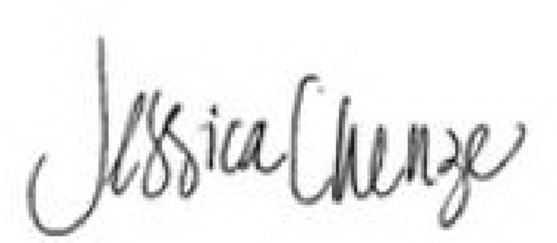
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37388	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWOODS VILLA INC	1212 GUNN ROAD GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37388015-0 On October 2, 2023, through October 3, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) active residents whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated October 2, 2023, for the specific Minnesota Food Code deficiencies.	0 480		
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;	0 810		

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0 810	Continued From page 2 (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 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 3 resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on October 3, 2023, at approximately 2:35 p.m. with Owner/Maintenance (OM-C) on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents. Record review of the available documentation indicated that the licensee did not provide training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed evacuation drills being done every three months. During interview, OM-C verified that the fire safety and evacuation plan for the facility lacked these	0 810		

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0 810	Continued From page 4 provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for three of three employees (clinical nurse supervisor (CNS)-B) and unlicensed personnel (ULP)-D, ULP-G). 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	01290		

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01290	Continued From page 5 or has the potential to affect a large portion or all the residents). The findings include: CNS-B CNS-B was hired on June 23, 2023, to provide direct nursing care services to the facility's residents and provide supervision to unlicensed personnel. CNS-B's record lacked documentation of a background study affiliated with the facility's license. ULP-D ULP-D was hired on May 29, 2023, to provide direct care services to the facility's residents. ULP-D's record lacked documentation of a background study affiliated with the facility's license. On October 2, 2023 at 4:17 p.m., the surveyor observed ULP-D administer R1's afternoon medications. ULP-G ULP-G was hired on October 1, 2023, to provide direct care services to the facility's residents. On October 3, 2023, at 8:22 a.m., the surveyor observed ULP-D provide morning cares for R1. During morning cares R1, stated to ULP-D that ULP-G removed his compression stockings (TEDs) last evening (October 2, 2023). ULP-D and ULP-G's record lacked documentation of a background study affiliated with the facility's license.	01290		

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01290	Continued From page 6 On October 3, 2023, at 3:15 p.m., LALD-A stated the facility had recently experienced management and licensing changes with health facility identification (HFID) numbers. LALD-A stated the two HFID numbers were mixed up and the affiliation within NetStudy 2.0 was completed under the wrong HFID number for CNS-B, ULP-D and ULP-G. The licensee's Background Check policy dated September 27, 2023, indicated all employees, contractors, and volunteers of the facility are subject to the background study requirements when providing direct cares, training, supervision, counseling, consultation, or medication assistance to persons served by the program and all employees must pass a background study. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted 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	01620		

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01620	Continued From page 7 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing 14-day resident reassessment for one of two residents (R2), and not to exceed 90 calendar days from the date of the last assessment utilizing the uniform assessment tool for two of two residents (R2, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses included diabetes mellitus type II. R2's service plan dated August 25, 2023,	01620		

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01620	Continued From page 8 indicated R2 received services to include medication management, blood sugar (glucose) checks, meal prep, housekeeping, and laundry. On October 2, 2023, at 11:47 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's noon medication and conduct a glucose check with results of 149 milligrams per deciliter (mg/dL). R2's record included a comprehensive admission assessment dated June 14, 2023, however, lacked any other comprehensive reassessments. R2's 14-day assessment was 97 days overdue. R2's 90-day assessment was due on or by September 14, 2023, and was 19 days overdue. R1 R1's diagnosis included multiple sclerosis (MS). R1's service plan dated August 25, 2023, indicated R1 received services to include medication management, three times a week injection, assistance with transfers, compression stockings (TEDs), dressing, meal prep, hygiene, showering, oral care, mobility, housekeeping, and laundry. On October 2, 2023, at 4:17 p.m., the surveyor observed ULP-D administer R1's afternoon medication and drain R1's urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). R1's record included two comprehensive assessments dated January 8, 2023, and July 18, 2023. R1's 90-day assessment was due on or by April 8, 2023, and was 98 days overdue.	01620		

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01620	Continued From page 9 On October 3, 2023, at 3:15 p.m., licensed assisted living director (LALD)-A confirmed ongoing reassessments had not been completed as required. LALD-A stated clinical nurse supervisor (CNS)-B was in charge of assessment completions and "they should have been done, it was known. We have a checklist, audit sheet of when they were last done". The licensee's Initial and On-Going Nursing Assessment of Residents policy dated September 27, 2023, indicated nurses would conduct assessments, monitoring, and reassessments at pre-admission, 14-day, and at least every 90 days as indicated. Ongoing monitoring and review would be conducted as needed based on changes in the resident needs and will not exceed 90 calendar days from the last review date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	01650		

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01650	Continued From page 10 (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R2, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnosis included diabetes mellitus type II.	01650		

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01650	Continued From page 11 R2's service plan dated August 25, 2023, indicated R2 received services to include medication management, blood sugar (glucose) checks, meal prep, housekeeping, and laundry. On October 2, 2023, at 11:47 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's noon medication and conduct a glucose check with results of 149 milligrams per deciliter (mg/dL). R1 R1's diagnosis included multiple sclerosis (MS). R1's service plan dated August 25, 2023, indicated R1 received services to include medication management, three times a week injections, assistance with transfers, compression stockings (TEDs), dressing, meal prep, hygiene, showering, oral care, mobility, housekeeping, and laundry. On October 2, 2023, at 4:17 p.m., the surveyor observed ULP-D administer R1's afternoon medication and drain R1's urinary catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid). R1 and R2's Service Plans dated August 25, 2023, lacked the following required content: - a description of the services to be provided, and the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring assessments of the residents; and - the schedule and methods of monitoring staff	01650		

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(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
01650	Continued From page 12 providing services. On October 3, 2023, at 3:25 p.m., licensed assisted living director (LALD)-A verified R1 and R2's service plans did not include a description of the services to be provided, and the frequency of each service, schedule and method of monitoring assessments or schedule and methods of monitoring staff, according to the resident's current assessment and resident preferences or the identification of staff or categories of staff who would provide the services. The licensee's Service Plan policy dated September 27, 2023, indicated the service plan must include a description of the services to be provided, and the frequency of each service, schedule and method of monitoring assessments or schedule and methods of monitoring staff, according to the resident's current assessment and resident preferences or the identification of staff or categories of staff who would provide the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=F	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	01730		

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	37388	A. BUILDING: _____ B. WING _____	10/03/2023

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01730	Continued From page 13 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 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 develop and maintain a current individualized medication management plan for each resident to include all	01730		

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01730	Continued From page 14 required content for two of two resident (R2, R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During the entrance conference on October 2, 2023, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R2 R2's diagnosis included diabetes mellitus type II. R2's service plan dated August 25, 2023, indicated R2 received services to include medication management. R2's prescriber orders dated June 14, 2023, included: atorvastatin 80 milligram (mg) daily for cholesterol, Certavite 1 tab daily for vitamin supplement, Digoxin 125 microgram (mcg) daily for heart rate stabilizer, lisinopril 2.5 mg daily for blood pressure, metoprolol 25 mg daily for heart stabilizer, vitamin B 100 mg daily vitamin supplement, pantoprazole 40 mg daily for digestive support, aspirin 81 mg daily antiplatelet, clopidogrel 75 mg daily anticoagulant, bupropion hydrochloride 150 mg daily for depression, rexulti 0.5 mg daily for depression, Symbicort 160-4.5 mcg/act twice daily for lung health, insulin aspartame 100 units/milliliter (ml) 8 units three times daily (TID) for glucose control,	01730		

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01730	Continued From page 15 acetaminophen 500 mg twice daily for pain, gabapentin 400 mg TID for nerve pain. On October 2, 2023, at 4:01 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's evening medications and insulin. R2's record lacked an individual medication management plan. R1 R1's diagnosis included multiple sclerosis (MS). R1's service plan dated August 25, 2023, indicated R1 received services to include medication management. On October 3, 2023, at 7:46 a.m., the surveyor observed ULP-D administer R1's morning medications. R1's prescriber orders dated January 6, 2023, included: aspirin 81 mg two tabs daily for antiplatelet, baclofen 10 mg take two tabs daily muscle relaxer, clopidogrel 75 mg 1 tab daily anticholesterol, Flexeril 10 mg daily muscle spasms, divalproex sodium 625 mg twice daily Bipolar, donepezil 5 mg daily dementia, duloxetine 60 mg 1 tab daily depression, Eucerin ointment topically twice daily for dry skin, ferrous sulfate 325 mg twice daily vitamin deficiency, finasteride 5 mg daily for benign prostatic hyperplasia, Flonase 50 mcg two sprays daily allergies, copaxone 40 mg sub-Q three times weekly for MS, hydroxyzine 25 mg twice daily for anxiety, lanolin topical twice daily for dry skin, magnesium oxide 400 mg daily vitamin deficiency, memantine 5 mg daily for dementia, metformin 500 mg daily for diabetes management, oxycodone 5 mg daily for pain,	01730		

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01730	Continued From page 16 pantoprazole 40 mg daily for acid reflux, polyethylene glycol 17G daily for constipation, pregabalin 150 mg twice daily for nerve pain, quetiapine 100 mg take one and a half tabs daily for Bipolar, simvastatin 40 mg 1 tab daily for anticholesterol, tamsulosin 0.4 mg daily for benign prostatic hyperplasia, trazadone 50 mg one tab daily for depression, vitamin B-12 1000 mcg daily vitamin supplement, vitamin D3 2000 units daily vitamin supplement. R1's Individualized Medication Management Plan dated December 19, 2022, did not include: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific resident instructions relating to the administration of medications; - identification of medication management tasks that may be delegated to unlicensed personnel; and - any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On October 3, 2023, at 10:27 a.m., licensed assisted living director (LALD)-A stated R2's medication management plan was incomplete and licensee was unable to locate an individual medication management plan for R1. LALD-A stated, "we didn't have one, I had her [CNS-B] do one now, it's dated todays date, but it's done". The licensee's Individualized Medication, Treatment and Therapy Management Plans policy dated September 27, 2023, indicated the	01730		

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01730	Continued From page 17 registered nurse (RN) would develop a medication management plan for each resident receiving medication management services and the plan would include the above noted items. Additionally, the policy indicated medication management plans would be current and updated when there were changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	01910		

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01910	Continued From page 18 Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included schizophrenia and diabetes mellitus type II. R3's service plan dated November 18, 2021, indicated R3 received services to include medication management, vital sign monitoring, housekeeping and laundry. R3's June 2023, Medication Administration Record (MAR) indicated R3 received the following scheduled medications: atorvastatin 40 milligrams (mg) daily cholesterol reducer, desmopressin 0.1 mg daily antidiuretic, famotidine 20 mg daily acid reducer, folic acid 1 mg daily vitamin deficiency, losartan 25 mg daily blood pressure reducer, oxybutynin 10 mg daily for overactive bladder, clozapine 600 mg daily antipsychotic, victoza 18 mg/3 milliters (ml) inject 1.8 mg daily treats diabetes, clozaril 650 mg daily antipsychotic, vitamin D3 1000 units daily vitamin deficiency, Vicks vaporub ointment 2 grams (G) daily congestion reducer, tab-o-vite multivitamin	01910		

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01910	Continued From page 19 daily vitamin deficiency, jardiance 25 mg daily diabetic management, nicotine 14 mg patch daily nicotine supplement, magnesium oxide 400 mg twice daily vitamin deficiency, metoprolol 50 mg twice daily blood pressure reducer, lorazepam 2 mg twice daily antianxiety, sertraline 100 mg daily for depression, lamotrigine 200 mg daily for bipolar, trihexyphenidyl 5 mg daily for muscle spasms, donepezil 10 mg daily cognition stabilizer, memantine 10 mg twice daily treats dementia, aripiprazole 30 mg daily treats bipolar. The licensee's Admission and Discharge Roster, undated, indicated R3 was admitted on November 18, 2021, and was discharged on June 12, 2023. R3's discharge summary dated June 12, 2023, written by clinical nurse supervisor (CNS)-B indicated R3 was transferred to another facility and medications were sent with R3. R3's record did not contain a medication disposition summary. On October 2, 2023, at 12:44 p.m., housing coordinator (HC)-E stated she was unable to locate a medication disposition for R3, "but we counted them". HC-E stated she was unaware it was a requirement to document a medication disposition and retain it in the residents record. The licensee's Disposition or Disposal of Medications policy dated September 27, 2023, indicated a residents current medications that are secured or stored by facility and given to the resident or residents representative when medication management services are terminated would be documented in the resident's record to include the name of person to whom medications	01910		

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01910	Continued From page 20 were given, time and date, name of each medication and amount of remaining medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	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	01940		

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01940	Continued From page 21 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan with all required content for two of two residents (R2, R1) who received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 2, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy services to residents. R2 R2's diagnosis included diabetes mellitus type II. R2's service plan dated August 25, 2023, indicated R2 received services to include blood sugar (glucose) checks three times daily. On October 2, 2023, at 11:47 a.m., the surveyor observed unlicensed personnel (ULP)-D conduct a glucose check with results of 149 milligrams per deciliter (mg/dL).	01940		

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01940	Continued From page 22 R1 R1's diagnosis included multiple sclerosis (MS). R1's service plan dated August 25, 2023, indicated R1 received services to include compression stockings (TEDs) treatments daily. On October 3, 2023, at 8:22 a.m., the surveyor observed ULP-D apply R1's TED stockings. R2 and R1's records lacked an Individualized Treatment and Therapy plan to include the following: - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On October 3, 2023, at 3:15 p.m., LALD-A verified R1 and R2's Individualized Treatment and Therapy Plan lacked the above noted requirements and stated clinical nurse supervisor (CNS)-B was "correcting that now and adding the specifics". The licensee's Individualized Medication, Treatment and Therapy Management Plans policy dated September 27, 2023, indicated the registered nurse (RN) would develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. Additionally, the policy indicated the individual treatment plan would include the above	01940		

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01940	Continued From page 23 noted items. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record for two of two resident (R2, R1).	01950		

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01950	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnosis included diabetes mellitus type II. R2's service plan dated August 25, 2023, indicated R2 received services to include blood sugar (glucose) checks three times daily. On October 2, 2023, at 11:47 a.m., the surveyor observed unlicensed personnel (ULP)-D conduct a glucose check with results of 149 milligrams per deciliter (mg/dL). The surveyor asked ULP-D to show the surveyor where instructions could be found for performing the glucose check, parameters and when staff should notify a nurse. ULP-D showed the surveyor in the electronic record a task labeled Blood Glucose Monitoring. The instructions directed to check glucose three times daily and as needed (PRN). The instructions lacked parameters and instructions of when a ULP should notify a nurse. R1 R1's diagnosis included multiple sclerosis (MS). R1's service plan dated August 25, 2023, indicated R1 received services to include compression stockings (TEDs) treatments daily. On October 3, 2023, at 8:22 a.m., the surveyor observed ULP-D apply TED stockings for R1. The	01950		

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01950	Continued From page 25 surveyor asked what ULP-D would monitor R1 for with the use of TED stockings. ULP-D stated, "our nurses teach us no wrinkles, they go all the way up, that's what I was taught". ULP-D showed the surveyor a task labeled TEDs in the electronic record, however, the electronic record did not provide specific instructions for applying or removing R1's TEDs. On October 3, 2023, at 3:15 p.m., the surveyor interviewed licensed assisted living director (LALD)-A. The surveyor asked LALD-A if specific instructions should be provided in writing to staff for treatments being administered for R1 and R2. LALD-A stated clinical nurse supervisor (CNS)-B was new and operations had not been smooth enough to get details into areas it was needed. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated September 27, 2023, indicated the RN may delegate to unlicensed personnel the task of providing assistance with treatments if the following requirements were met: - the complete procedure for checking the resident's treatment and therapy profile and any additional information; - before performing the procedures, the RN has instructed the unlicensed personnel in the proper method to administer the treatment and therapy and the unlicensed personnel have demonstrated the ability to competently follow the procedure; and - the RN has developed written, specific instructions for each resident; and - the RN has communicated with the unlicensed personnel about the individual needs of the resident. No further information was provided.	01950		

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01950	Continued From page 26 TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language disclosing electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 2, 2023, at 10:00 a.m., the surveyor entered the facility and noted a small "security camera in use sign" posted on front door.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37388	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWOODS VILLA INC	1212 GUNN ROAD GRAND RAPIDS, MN 55744

(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
03090	Continued From page 27 On October 2, 2023, at 10:20 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. LALD-A stated there was one active video camera upstairs in the main living area. LALD-A stated she had not had a chance to change the sign to include the specific statutory language required to be posted regarding electronic monitoring devices and confirmed licensee lacked required posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/02/23*
Time: 12:14:46
Report: 7939231166

Food and Beverage Establishment Inspection Report

Location:
Northwoods Villa Inc
1212 Gunn Road
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:
ID #: 0037760
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189995513
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.

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 MUST PROVIDE PROPER TEST KIT FOR THE SANITIZER. BLEACH MUST BE AT A 50PPM MINIMUM CONCENTRATION

Comply By: 10/02/23

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

ESTABLISHMENT WAS NOT USING AN APPROVED SANITIZER FOR THE KITCHEN AREA. BLEACH WAS DISCUSSED

Comply By: 10/02/23

Food and Equipment Temperatures

Process/Item: PASTA
Temperature: 39 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Type: Full
Date: *10/02/23*
Time: 12:14:46
Report: 7939231166
Northwoods Villa Inc

Food and Beverage Establishment Inspection Report

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

DISCUSSION
WARE WASH MACHINE TEST PAPERS LEFT WITH (TEMPERATURE) BRITTNEY. PLEASE ENSURE STICKER TURNS BLACK(160F). PLEASE EMAIL PICTURES OF THE RESULTS

SANITZER REQUIREMENTS

GLOVE USE AND HAND WASHING

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 7939231166 of 10/02/23.

Certified Food Protection Manager:_____

Certification Number: APPLIED Expires: / /

Signed:_____
BRITTNEY PERSING
CFPM

Signed:_____
RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us