Electronically Delivered

April 24, 2024

Licensee
The Green Prairie Assisted Living
810 2nd Avenue Northwest
Plainview, MN  55964

RE:  Project Number(s) SL30464015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

**STATE CORRECTION ORDERS**

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

**IMPOSITION OF FINES**

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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 survey:

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

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

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

The correction order documentation should include the following:

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

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

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

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

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

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

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

If you have any questions, please contact me.

Sincerely,

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

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL30464015-0<br>On April 1, 2024, through April 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 35 residents; 18 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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 0 480 | Continued From page 1<br>following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br>The findings include:<br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(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.<br>(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 | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 0 510 | Continued From page 2<br><br>control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by one of two unlicensed personnel (ULP-G) during medication administration.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>On April 1, 2024, at 2:10 p.m. ULP-G donned gloves at the medication cart, unlocked the medication cart, removed a bubble pack of medication, punched out one tablet directly into a medication cup, documented the medication set up on the computer, went to R5's room, knocked on the door, got a drink from R5's mini-fridge in the apartment, gave the medications, and then removed her gloves and used hand sanitizer. ULP-G used the same set of gloves while touching multiple surfaces and administered | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 0 510 | Continued From page 3<br>medications to R5.<br><br>On April 1, 2024, at 3:10 p.m. ULP-G donned clean gloves, opened the medication cart, pulled out one tablet of medication, one vial of nebulizer solution, and a tube of diclofenac gel (a gel applied to the body for pain relief). With the same gloves, ULP-G documented the medication set up on the computer, used a pen and a notepad to write a note, and went to R3's room. With the same gloves, ULP-G knocked on the door, entered the room and administered R3's oral medication, applied the diclofenac gel to both knees and assisted with setting up R3's nebulizer. ULP-G used the same set of gloves and touched multiple surfaces through all steps of medication set up and administration with R3.<br><br>On April 1, 2024, at 3:20 p.m. ULP-G donned clean gloves at the medication cart, opened drawers of the medication cart, pulled out R2's bubble cards of medications, punched out two tablets of acetaminophen and Tums directly into her gloved hands and documented the medication set up on the computer. ULP-G pulled out R2's eye drops, went to the refrigerator, obtained a cup of applesauce, and went to R2's room. ULP-G knocked on and opened R2's door and gave the oral medications. ULP-G used the same gloves and administered R2's eye drops. ULP-G then removed her gloves and washed her hands.<br><br>On April 1, 2024, at 3:30 p.m. ULP-G set up R6's medications at the medication cart, donned clean gloves after medication set up, documented on the computer, went to R6's room, knocked on the door, poured the oral medications into her gloved hands, and administered to R6. Using the same gloves, ULP-G dispensed an undetermined | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 0 510 | Continued From page 4<br><br>amount of diclofenac gel into her gloved hands and applied to R6's knees.<br><br>On April 1, 2024, at 3:45 p.m. ULP-G donned clean gloves, wiped R5's middle finger in preparation for a blood sugar check. ULP-G poked R5's finger with a lancet and obtained a drop of blood for the glucometer (an electronic unit to measure blood sugar levels) strip. ULP-G disposed of the lancet and the glucometer test strip into the sharps container and removed her gloves. Without washing her hands, ULP-G donned a clean set of gloves, documented the reading on the computer, used a Sani-cloth to wipe the glucometer. ULP-G answered a phone call, and then pulled out R5's insulin pen for insulin administration and then removed her gloves, washed her hands, and donned a clean set of gloves for insulin pen preparation and administration. ULP-G failed to wash her hands after removing the gloves used for R5's blood sugar check and before she donned clean gloves, touching multiple surfaces.<br><br>On April 1, 2024, at 3:55 p.m. ULP-G stated she didn't usually wear gloves when setting up medications, was nervous and thought she was doing what she was supposed to. ULP-G further stated she didn't realize how many surfaces she had touched while setting up medications, directly touching medications, and that she had gone straight to the residents' rooms with the same gloves, kept them on throughout that medication pass, and sometimes used them with multiple routes of medication administration.<br><br>On April 1, 2024, at 4:20 p.m. clinical nurse supervisor (CNS)-A stated she did not train the ULP to wear gloves while setting up medications, and the ULP should be washing/sanitizing their | 0 510 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 0 510 | Continued From page 5<br><br>hands following touching surfaces and before administering medications to the residents. Furthermore, she stated when the ULP were administering topical or eye medications, the ULP were expected to sanitize/wash hands and don a clean set of gloves.<br><br>The licensee's Standard Precautions policy dated, August 1, 2021, indicated hands should be washed after removing gloves and after any direct contact with body secretions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a | 0 800 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 0 800 | Continued From page 6<br><br>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).<br><br>Findings include:<br><br>Fire Rating:<br><br>On a facility tour on April 1, 2024, at 11:30 a.m., with regional maintenance director (RMD)-D, the surveyor made the following observations of facility hazards and disrepair:<br><br>During the tour, survey staff observed holes in the fire resistive rated wall in the 1st floor recycling room.<br><br>Survey staff explained to RMD-D, that fire resistant rated wall in a state-licensed facility must meet the minimum state fire code standard for fire rating and the fire rating shall be maintained at all times.<br><br>Extension Cord:<br><br>It was observed that an extension cord was being used permanently, feeding a time clock in the kitchen. This extension cord was running through the wall from the 1st floor storage/recycling room. Extension cords shall be used per the manufacture instructions and their use shall comply with the Minnesota State Fire Code.<br><br>During a facility tour on April 1, 2024, at 11:30 a.m., licensed assisted living regional | 0 800 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 0 800 | Continued From page 7<br>maintenance director RMD-D, verified the above listed observations while accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 800 | | |
| 0 920 SS=C | 144G.50 Subd. 2 (c) Contract information<br><br>(c) The contract must include:<br>(1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license;<br>(2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount;<br>(3) a delineation of the cost and nature of any other services to be provided for an additional fee;<br>(4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract;<br>(5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation;<br>(6) billing and payment procedures and requirements; and<br>(7) disclosure of the facility's ability to provide specialized diets.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the | 0 920 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 0 920 | Continued From page 8<br><br>licensee failed to execute a written assisted living contract with the required content for three of three residents (R1, R2, R3).<br><br>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).<br><br>The findings include:<br><br>On April 1, 2024, at 12:00 p.m. during a facility tour, the surveyor noted the facility license posted in the main entryway. The license indicated the licensee held an Assisted Living Facility (ALF) license, with an effective date of May 1, 2023, and an expiration date of April 30, 2024.<br><br>The licensee failed to provide a contract to include the following required content:<br>- a disclosure of the category of assisted living facility license held by the facility<br><br>R1<br>R1's Assisted Living Agreement (used as the Service Plan), dated February 8, 2024, indicated he received services to include medication administration, urinary catheter care, and assistance with bathing and laundry.<br><br>R1's Assisted Living Contract dated August 10, 2021, indicated the licensee held an Assisted Living with Dementia Care license.<br><br>R2<br>R2's Assisted Living Agreement (used as the | 0 920 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 0 920 | Continued From page 9<br><br>Service Plan), dated April 1, 2024, indicated she received services to include medication administration, behavior support, and assistance with toileting and laundry/housekeeping.<br><br>R2's Assisted Living Contract dated August 13, 2021, indicated the licensee held an Assisted Living with Dementia Care license.<br><br>R3<br>R3's Assisted Living Agreement (used as the Service Plan), dated January 4, 2024, indicated she received services to include medication administration, insulin injections, blood sugar checks, daily weights, daily vital signs, daily application and removal of Velcro leg wraps, and assistance with bathing and housekeeping.<br><br>R3's Assisted Living Agreement dated August 6, 2021, indicated the licensee held an Assisted Living with Dementia Care license.<br><br>On April 2, 2024, at 10:30 a.m. licensed assisted living director/registered nurse (LALD/RN)-B indicated the contract was not accurate in identifying the proper license held by the licensee and likely affected many residents. The contract indicated an ALFDC license and should indicate an ALF license.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 920 | | |
| 01650 SS=F | 144G.70 Subd. 4 (f) Service plan, implementation and revisions to | 01650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 10<br>(f) The service plan must include:<br>(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;<br>(2) the identification of staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring assessments of the resident;<br>(4) the schedule and methods of monitoring staff providing services; and<br>(5) a contingency plan that includes:<br>(i) the action to be taken if the scheduled service cannot be provided;<br>(ii) information and a method to contact the facility;<br>(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<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R1, R2, R3) who received services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 01650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 11<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 was admitted under the facility's Assisted Living Facility License (ALF) on August 10, 2021.<br><br>R1's Assisted Living Agreement (used as the Service Plan) dated February 8, 2024, indicated he received services to include medication administration, urinary catheter care, and assistance with bathing and laundry.<br><br>On April 2, 2024, at 5:45 a.m. unlicensed personnel (ULP)-H assisted R1 with catheter care, a skin check and incontinence brief change.<br><br>R2<br>R2 was admitted under the facility's Assisted Living Facility License (ALF) on August 13, 2021.<br><br>R2's Assisted Living Agreement (used as the Service Plan) dated April 1, 2024, indicated she received services to include medication administration, behavior support, and assistance with toileting and laundry/housekeeping.<br><br>On April 1, 2024, at 3:20 p.m. ULP-G assisted R2 with medication administration to include three oral medications and one eye drop to both eyes.<br><br>R3<br>R3 was admitted under the facility's Assisted Living Facility License (ALF) on August 6, 2021. | 01650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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<br><br>R3's Assisted Living Agreement (used as the Service Plan) dated January 4, 2024, indicated she received services to include medication administration, insulin injections, blood sugar checks, daily weights, daily vital signs, daily application and removal of Velcro leg wraps, and assistance with bathing and housekeeping.<br><br>On April 2, 2024, at 3:10 p.m. ULP-G assisted R3 with administration of one oral medication, one topical pain medication to both knees, and a nebulizer breathing treatment.<br><br>R1, R2, and R3's Service Plans lacked the required content to include the schedule and methods for monitoring staff providing services.<br><br>On April 2, 2024, at 12:05 p.m. licensed assisted living director/registered nurse (LALD/RN)-B indicated the corporate office had made edits to the service plan addendum to include this verbiage; however, this facility was transitioning the paperwork processes to electronic medical record and had not utilized the most updated version. LALD/RN-B indicated this likely impacted all 17 residents who received services and licensee would provide an addendum for all residents to include the required content.<br><br>The licensee's Service Plan policy dated August 1, 2021, indicated the Service Plan would include the frequency of sessions of supervision of staff and type of personnel who will supervise staff.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01730 | Continued From page 13 | 01730 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(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:<br>(1) a statement describing the medication management services that will be provided;<br>(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;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(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.<br>(b) The medication management record must be current and updated when there are any changes. | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01730 | Continued From page 14<br><br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan included all required content for one of three residents (R3) receiving medication services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>R3's diagnoses included type 2 diabetes with insulin dependence (when the body cannot effectively manage blood sugars), heart failure with lymphedema (a condition resulting in fluid retention due to a blockage of the lymphatic system), chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs) with oxygen dependence, and kidney disease.<br><br>R3's Assisted Living Agreement (used as the Service Plan), dated January 4, 2024, indicated she received services to include medication administration. | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01730 | Continued From page 15<br><br>On April 1, 2024, at 3:10 p.m. unlicensed personnel (ULP)-G was observed to assist R3 with her scheduled albuterol nebulizer. ULP-G dispensed the vial of solution into R3's nebulizer cup and R3 was able to self-administer the nebulizer. ULP-G indicated R3 was quite independent with her nebulizer administration, staff assisted with set up, and ensured she was administering the medication solution when it was scheduled.<br><br>On April 1, 2024, at 3:10 p.m. ULP-G assisted R3 with medication administration. ULP-G set up and gave one oral medication, one topical (on the skin) pain medication, and assisted with setting up R3's scheduled albuterol nebulizer treatment.<br><br>R3's medication administration record (MAR) dated March 2024, indicated scheduled medications to include one for diarrhea prevention, one for gout, two for blood thinning, one for kidney disease, one for CHF, one for COPD, two for high blood pressure, one for mild pain, one for gastric reflux, one for cholesterol, one for the heart rate and strength, four supplements, one topical pain medication, two insulin injections for type 2 diabetes, one antifungal cream and one nebulizer for COPD. Additionally, R3's MAR indicated as needed (PRN) medications to include two for allergies/nasal congestion, two for constipation, one topical for mild pain, one for increased weight, one for angina (heart pain), and two for shortness of breath (related to CHF and COPD).<br><br>R3's MAR dated March 2024, indicated she had scheduled Albuterol 0.83%, 3 milliliters (ml) via nebulizer four times daily and Albuterol 0.83 %, 3 ml two times daily via nebulizer as needed (PRN) for shortness of breath. Additionally, R3's MAR | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01730 | Continued From page 16<br><br>indicated an Albuterol HFA inhaler two puffs, every four hours PRN for shortness of breath.<br><br>R3's Medication Plan (found within the registered nurse (RN) comprehensive assessment) dated February 20, 2024, indicated staff administered R3's medications.<br><br>R3's Medication Plan lacked direction from the nurse for which form of the Albuterol (nebulizer verses inhaler) when used as a PRN should be used first and/or second and how much time should be spaced between scheduled and PRN dosing.<br><br>On April 3, 2024, at 1:15 p.m. clinical nurse supervisor (CNS)-A stated there was no clear direction from the provider regarding which form of Albuterol should be used first in a PRN situation. She indicated she was not able to make that decision and would need to contact the prescriber for further direction.<br><br>The licensee's Development of the Individualized Medication Treatment and Therapy Management and Individualized Medication and Treatment Record policy dated November 2019, indicated the licensee would provide identification of any specific client instructions regarding medication, treatments, or therapy our agency staff will administer.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01760 SS=D | 144G.71 Subd. 8 Documentation of administration of medication | 01760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01760 | Continued From page 17<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for two of five residents (R3, R6) receiving medication services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>R3<br>R3 began receiving services under the facility's Assisted Living Facility license on August 6, 2021.<br><br>R3's diagnoses included type 2 diabetes (when | 01760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01760 | Continued From page 18<br><br>the body cannot effectively manage blood sugars) with insulin dependence, congestive heart failure (CHF when the heart is functioning poorly causing fluid retention), lymphedema (a condition resulting in fluid retention due to a blockage of the lymphatic system), chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs) with oxygen dependence, and kidney disease.<br><br>R3's Assisted Living Agreement (used as the Service Plan), dated January 4, 2024, indicated she received services to include medication administration.<br><br>R3's prescriber order dated May 19, 2023, indicated Diclofenac 1% gel, 4 grams (gm) to both knees four times daily.<br><br>On April 1, 2024, at 3:10 p.m. unlicensed personnel (ULP)-G was observed to take R3's tube of diclofenac gel to her room and squeeze an undetermined amount of medication onto her gloved fingers and then applied to R3's knees. ULP-G failed to use the designated measuring tool to accurately measure the prescribed amount/dose of medication for R3.<br><br>R6<br>R6 started receiving services under the facility's Assisted Living License on August 1, 2021.<br><br>R6's diagnoses included anxiety, type 2 diabetes, CHF, COPD, and neuropathy (nerve pain) of the lower extremities.<br><br>R6's Assisted Living Agreement (used as the Service Plan), dated January 1, 2024, indicated she received services to include medication | 01760 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01760 | Continued From page 19<br>administration.<br><br>R6's record included an order dated October 6, 2023, for Diclofenac 1% gel give 4 gm to affected area (applied to the knees), four times daily.<br><br>On April 1, 2024, at 3:30 p.m. ULP-G was observed to bring R6's tube of diclofenac 1% gel to R6's room and squeezed an undetermined amount of medication onto her gloved fingers and then applied to R6's knees. ULP-G failed to use the designated measuring tool to accurately measure the prescribed amount/dose of medication for R6.<br><br>On April 1, 2024, at 4:20 p.m. clinical nurse supervisor (CNS)-A stated she expected the staff to ensure proper dosing of the topical gel by using the included measuring tool/strip and not guess or estimate the quantity/dose.<br><br>The licensee's Topical Medication Administration procedure dated March 22, 2024, indicated the staff would follow the instructions on the MAR and ensure the proper dose of medication was set up and administered.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01760 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>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. | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 20<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. This had the potential to affect the licensee's current residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>During the entrance conference on April 1, 2024, at 11:00 a.m. licensed assisted living director/registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-B indicated the licensee provided medication management to 17 residents, and medications were securely stored in locked medication carts on both floors of the facility. When not in use, the first-floor medication cart was brought to the second-floor staff desk area where the second-floor medication cart was kept.<br><br>On April 1, 2024, from 2:10 p.m. to 3:50 p.m. the surveyor observed unlicensed personnel (ULP)-G set up and administer medications and use blood sugar testing equipment from the second-floor medication cart for residents (R2, R3, R5, R6, and R7). During that entire observation time, | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 21<br><br>ULP-G left the medication cart unlocked. The surveyor noted several residents and visitors pass by the unlocked medication cart.<br><br>On April 1, 2024, at 3:55 p.m. ULP-G stated she knew to lock the medication cart when not in the vicinity to ensure medication security.<br><br>On April 1, 2024, at 4:20 p.m. clinical nurse supervisor (CNS-A) stated she expected the ULP to ensure medication security by locking it each time they left it.<br><br>The licensee's Storage of Medications policy dated December 2019, indicated medications managed outside of a tenant's private living space must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01950 SS=D | 144G.72 Subd. 4 Administration of treatments and therapy<br><br>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 | 01950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01950 | Continued From page 22<br><br>personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:<br>(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;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) notified the registered nurse (RN) regarding concerns related to a treatment for one of four residents (R3) receiving treatments.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>R3's diagnoses included type 2 diabetes with insulin dependence (when the body does not effectively manage blood sugar), congestive heart failure (CHF when the heart is functioning poorly causing fluid retention), lymphedema (a condition resulting in fluid retention due to a blockage of the lymphatic system), chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung | 01950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01950 | Continued From page 23<br><br>disease that causes obstructed airflow from the lungs) with oxygen dependence, and kidney disease.<br><br>R3's Assisted Living Agreement Addendum (used as the Service Plan) dated January 4, 2024, included donning, and removing Velcro wraps daily. The service plan directed ULP to report to the RN, any redness, warmth, swelling, or increased pain associated with the use of the Velcro wraps.<br><br>On April 2, 2024, at 7:10 a.m. ULP-H was observed to don black knee-high compression stockings to R3's lower extremities. She then placed a Velcro compression wrap on each lower extremity. The surveyor noted an area on both lower extremities along the shin area to be red and with small blisters. The area was about the size of an adult hand. ULP-H indicated the compression stockings and Velcro wraps were put on in the morning and removed in the evening. ULP-H did not know how long the shin areas had been red with blisters.<br><br>The ULP failed to report concerns with R3's lower extremities with redness and blisters as was directed in R3's treatment plan/service plan addendum.<br><br>On April 3, 2024, at 1:10 p.m. clinical nurse supervisor (CNS)-A indicated she was not aware the ULP were assisting R3 with compression stockings. She stated only tubi-stockinette (a loose-fitting material) was to be used as a skin protectant with the compression Velcro wraps due to her lymphedema and concerns with skin breakdown. CNS-A stated R3 had chronic redness along the shin area of both legs but was not aware of any blisters. CNS-A indicated the | 01950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01950 | Continued From page 24<br><br>ULP know compression stockings required an order, were considered a treatment and needed to be communicated with the nurse. CNS-A indicated R3's treatment plan/service plan addendum included direction for the ULP to notify the nurse for any concerns with R3's skin.<br>At 2:10 p.m. CNS-A stated she talked to R3 who indicated she was the one who bought the compression stockings and gave direction to the ULP.<br><br>The licensee's Development of the Individualized Medication Treatment and Therapy Management and Individualized Medication and Treatment Record policy dated November 2019, indicated the licensee would provide:<br>-procedure for staff to notify the RN when there is a problem with any medication management service;<br>-any client specific requirements relating to documentation of medication, treatment or therapy administration, verification that all medications, treatments, and therapies are administered as prescribed and monitoring of medication use to prevent possible complications of adverse reactions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01950 | | |
| 01960 SS=D | 144G.72 Subd. 5 Documentation of administration of treatments<br><br>Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01960 | Continued From page 25<br><br>administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented for one of four residents (R3) receiving treatments.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).<br><br>The findings include:<br><br>R3's diagnoses included type 2 diabetes with insulin dependence (when the body does not effectively manage blood sugar), congestive heart failure (CHF when the heart is functioning poorly causing fluid retention), lymphedema (a condition resulting in fluid retention due to a blockage of the lymphatic system), chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs) with oxygen dependence, and kidney disease.<br><br>R3's Assisted Living Agreement Addendum (used | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01960 | Continued From page 26<br><br>as the Service Plan) dated January 4, 2024, included donning, and removing Velcro wraps daily. The service plan directed unlicensed personnel (ULP) to report to the registered nurse (RN), any redness, warmth, swelling, or increased pain associated with the use of the Velcro wraps.<br><br>On April 2, 2024, at 7:10 a.m. ULP-H was observed to don black knee-high compression stockings to R3's lower extremities. She then placed a Velcro compression wrap on each lower extremity. ULP-H indicated the compression stockings and Velcro wraps were put on in the morning and removed in the evening.<br><br>The licensee donned R3's compression stockings without an order, without being indicated as a treatment, and failed to document the treatment or contact the licensee's nurse regarding the treatment being started.<br><br>On April 3, 2024, at 1:10 p.m. clinical nurse supervisor (CNS)-A indicated she was not aware the ULP were assisting R3 with compression stockings. She stated the only tubi-stockinette (a loose-fitting material) was to be used as a skin protectant with the compression Velcro wraps due to her lymphedema and concerns with skin breakdown. CNS-A stated R3 had chronic redness along the shin area of both legs but was not aware of any blisters. CNS-A indicated the ULP knew compression stockings required an order, were a treatment and needed to be communicated with the nurse.<br><br>On April 4, 2024, at 2:38 p.m. licensed assisted living director/registered nurse (LALD/RN)-B indicated she contacted CNS-A who shared she clarified the compression stocking use with R3. | 01960 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30464 | A. BUILDING: _____ B. WING _____ | 04/04/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE GREEN PRAIRIE ASSISTED LIV | 810 2ND AVENUE NW PLAINVIEW, MN 55964 |

| (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 |
|---|---|---|---|---|
| 01960 | Continued From page 27<br><br>R3 stated she bought the compression stockings about a month ago and directed the ULP to use them about three weeks ago. R3 indicated when she first received the Velcro compression wraps, she was provided a set of stockings and did not realize the stockings now used were compression stockings.<br><br>The licensee's Implementing Medication and Treatment Orders policy dated August 1, 2021, indicated orders can only be implemented when in direct contact with the licensed nurse. ULP will NOT implement orders or changes to orders unless in direct contact and instruction with the licensed nurse. The original signed order or faxed order will be placed in a designated place for the nurse to review at the next scheduled licensed nurse visit.<br>Furthermore, when appropriate, changes will be made to a resident's Service Plan.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT- Seven (7) days. | 01960 | | |

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *04/02/24*
Time: 11:06:06
Report: 7962241042

# Food and Beverage Establishment Inspection Report



**Location:**
The Green Prairie Assisted Liv
810 2nd Avenue Nw
Plainview, MN55964
Wabasha County, 79

**Establishment Info:**
ID #: 0039024
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 5075343191
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.

**3-500B Microbial Control: hot and cold holding**

***3-501.16A2*** ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

THERMOMETER INSIDE COOLER, PORTIONED SAUCES, GALLON OF MILK, CHOCOLATE SAUCE, MOVED TO NURSING HOME WALK-IN COOLER DURING INSPECTION UNTIL UNIT MAINTAINS 41 DEG OR LOWER. 64 DEG BUTTER PATS DISCARDED DURING INSPECTION

*Comply By: 04/02/24*

**3-500D Microbial Control: disposition of food**

***3-501.18A*** ***** Priority 1 *****

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

PORTIONED SAUCE 3/25 DISCARDED DURING INSPECTION

*Comply By: 04/02/24*

**5-200B Plumbing: cross connections**

***5-203.14A*** ***** Priority 1 *****

MN Rule 4626.1085A Water used under pressure in equipment in food and beverage establishments must be drained to a sanitary sewer through an air gap. Examples: refrigeration cooling water, water softener, and drained steam jacketed kettles.

ICE MACHINE DISCHARGE LINE DOES NOT HAVE AN AIR GAP, AIR GAP DOCUMENT WITH EXAMPLES SENT WITH REPORT

*Comply By: 04/02/24*

**4-300 Equipment Numbers and Capacities**

***4-302.13B*** ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO MAX/MIN THERMOMETER FOR DISH WASHING MACHINE, PICTURES SENT

*Comply By: 04/16/24*

**3-300C Protection from Contamination: equipment/utensils, consumers**

***3-304.12E***

MN Rule 4626.0275E Store food preparation or dispensing utensils that are used with non-TCS foods, such as ice, in a clean, protected location.

ICE SCOOP NOT PROTECTED, LYING ON TOP OF ICE MACHINE,

*Comply By: 04/02/24*

**4-400 Equipment Location and Installation**

***4-402.11A***

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

MISSING AND MOLDY CAULK DIRTY SIDE OF DISH MACHINE, INSTALL AND REPLACE AS NEEDED, HOOD NOT SEALED TO THE CEILING

*Comply By: 04/16/24*

**4-500 Equipment Maintenance and Operation**

***4-501.11AB***

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

HOT WATER SANITIZING DISH MACHINE NOT OPERATING AT TIME OF INSPECTION, IN PROCESS OF LEASING A DISH MACHINE, UNTIL INSTALLED ALL DISHES ARE SENT TO NURSING HOME KITCHEN. Continued at end of report:

*Comply By: 04/02/24*

**4-600 Cleaning Equipment and Utensils**

***4-601.11C***

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

FAN IN KITCHEN DUST/DIRTY, DISCONTINUE USING IN KITCHEN AS IT DISRUPTS THE BALANCED FLOW BETWEEN TEMPERED MAKE-UP AIR AND DISH MACHINE HOOD EXHAUST, THERE ARE ANSI/NSF APPROVED DISH DRYERS

*Comply By: 04/02/24*

Type: Full
Date: *04/02/24*
Time: 11:06:06
Report: 7962241042
The Green Prairie Assisted Liv

# Food and Beverage Establishment Inspection Report

**6-100 Physical Facility Construction Materials**

***6-101.11A1***

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

SEWER LINE UNDER SCRAP SINK HAS OPENINGS AROUND IT, INSTALL AN ESCUTCHEON PLATE AROUND OPENING. FLOOR DRAIN SERVICING ICE MACHINE DOES NOT HAVE A FLOOR DRAIN COVER

*Comply By: 04/16/24*

---

**Surface and Equipment Sanitizers**

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: wiping cloth bucket
Violation Issued: No

---

**Food and Equipment Temperatures**

Process/Item: Out of Refrigeration
Temperature: 64 Degrees Fahrenheit - Location: butterpats on counter in kitchen
Violation Issued: Yes

---

Process/Item: Hot Holding
Temperature: 177 Degrees Fahrenheit - Location: cream soup
Violation Issued: No

---

Process/Item: Delivered Meal Hot
Temperature: 190 Degrees Fahrenheit - Location: delivery from nursing home kitchen: pork
Violation Issued: No

---

Process/Item: Delivered Meal Hot
Temperature: 175 Degrees Fahrenheit - Location: delivery from nursing home kitchen: mixed veggies
Violation Issued: No

---

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: external thermometer
Violation Issued: No

---

Process/Item: Upright Cooler
Temperature: 45 Degrees Fahrenheit - Location: thermometer inside cooler, portioned sauces, gallon of milk, chocolate sauce, moved to nursing home walk-in cooler during inspection until unit maintains 41 degrees or lower
Violation Issued: Yes

---

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 3 | 1 | 5 |

Establishment Info:

Email reports to:
Deb Jacobson, Nursing Evaluator, Deb.Jacobson@state.mn.us
Marcy Marien, Kitchen Manager, mmarien@monarchmn.com

Current Floor/Wall/Ceiling finishes in kitchen:
- Floor: luxury vinyl floor, stained and worn around floor drains
- Cove Base: rubber

Continued from report:
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
4-501.11AB

* HOT BOX DELIVERING FOOD FROM NURSING HOME KITCHEN IS MELTED AND NO LONGER EASILY CLEANABLE

* GARBAGE DISPOSAL WIRED WITH EXTENSION CORD REMNANT

* BROKEN PLASTIC ICE SCOOP. DISCARDED DURING INSPECTION AND REPLACED WITH METAL SCOOP

**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 7962241042 of 04/02/24.

Certified Food Protection Manager: Marcy Marien

Certification Number: FM41191 Expires: 12/27/25

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

Signed: _____

Marcy Marien
Kitchne Manager

Signed: Heather Flueger

Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us