DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 2, 2024

Licensee
Brookstone Manor
722 North Pokegama Avenue
Grand Rapids, MN 55744

RE: Project Number(s) SL20077015

Dear Licensee:

On April 24, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 24, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 24, 2023 survey.

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.

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.

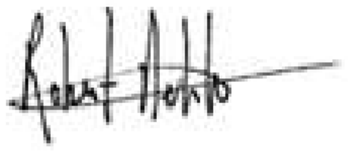
A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. §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

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

We urge you to review these orders carefully. If you have questions, please contact Bob Dehler at 651-201-3710.

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

Sincerely,



Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20077	A. BUILDING: _____ B. WING _____	R 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE MANOR	722 NORTH POKEGAMA AVENUE 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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL20077015-3 On April 24, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on Janurary 30, 2024. At the time of the survey, there were 38 residents; all receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{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.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	{0 510}		

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{0 510}	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	{0 650}		

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{0 650}	Continued From page 2 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}		
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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. This MN Requirement is not met as evidenced by: 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 affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	{0 800}		

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{0 800}	Continued From page 3 Findings include: On a facility tour on April 24, 2024, at 10:30 a.m. with and maintenance (M)-C, it was observed that resident rooms C-108 and C-103 in the lower level of the C-wing are in disrepair and, missing floor covering. Resident rooms as identified on the facility floor plan are required to be maintained with floor covering and wall finishes for occupancy as approved at the time of construction. It was also observed the laundry room door provided with a closer does not automatically close and latch. The door automatically retracted to the open position instead of the closed position. It was stated by M-C, the closer was improperly adjusted and they will adjust so the door will automatically close and latch and not stay open automatically. Doors provided with self-closing devices are required to operate as designed and installed at the time of construction approval. During an interview on April 24, 2024, at 10:45 a.m., M-C, stated resident rooms C-108 and C-103 have not been repaired because they submitted a request for reconsideration to Minnesota Department of Health and are not going to repair the rooms. During the same interview it was also stated by M-C, the closer on the laundry room was improperly adjusted and the door stays open instead of closing automatically.	{0 800}		
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any	{0 900}		

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{0 900}	Continued From page 4 individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: No further action needed.	{0 900}		
{01290} SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	{01290}		

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{01290}	Continued From page 5 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: No further action needed.	{01290}		
{01760} SS=E	144G.71 Subd. 8 Documentation of administration of medication 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. This MN Requirement is not met as evidenced by: No further action needed.	{01760}		

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{01900} SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01900}		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: No further action needed.	{02310}		

Electronically Delivered

February 21, 2024

Licensee
Brookstone Manor
722 North Pokegama Avenue
Grand Rapids, MN 55744

RE: Project Number(s) SL20077015

Dear Licensee:

On January 30, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 24, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 24, 2023, survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last follow-up survey, completed on November 13, 2023, found not corrected at the time of the January 30, 2024, follow-up survey subject to penalty assessment is as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) = $500.00

The details of the violations noted at the time of this follow-up survey completed on January 30, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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.

IMPOSITION OF FINES:

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.

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.

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.

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.

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

Jessie Chenze

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

PMB

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{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	{0 510}		

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{0 510}	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	{0 650}		

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{0 650}	Continued From page 2 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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. This MN Requirement is not met as evidenced by: 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. 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 potential to affect a large portion or all of the residents). Findings include:	{0 800}		

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{0 800}	Continued From page 3 On a facility tour on January 30, 2024, at 1:00 p.m. with and maintenance (M)-C it was observed that the fire-resistant rated door A wing third floor west stairway did not self-close and latch. It was stated by M-C they are waiting for the contractor scheduled to install the new closer. Fire resistant rated doors are required to automatically close and latch. It was also observed the laundry room door provided with self-closing hinges does not automatically close and latch. It was stated by M-C, they are waiting for the contractor scheduled to install the new closer. Doors provided with self-closing devices are required to operate as designed and installed at the time of construction. It was observed the east stairway of A wing and west stairway of A wing were damaged by a roof leak. It was stated by M-C the roof repair and replacement is complete and they are waiting for the contractor which is scheduled to repair the ceiling damage. It was observed that resident rooms C-108 and C103 in the lower level of the C wing are vacant, in disrepair and, missing floor covering. Resident rooms are required to be maintained with floor covering and wall finishes as approved at the time of construction. During an interview on January 30, 2024, at 1:30 p.m., M-C stated they are waiting for the contractor scheduled to complete the installation of the door closers and repair the ceilings damaged by water.	{0 800}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20077	A. BUILDING: _____ B. WING _____	R 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE MANOR	722 NORTH POKEGAMA AVENUE 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
{0 900}	Continued From page 4	{0 900}		
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: No further action needed.	{0 900}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20077	A. BUILDING: _____ B. WING _____	R 01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
{01290}	Continued From page 5	{01290}		
{01290} SS=E	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: No further action needed.	{01290}		
{01760} SS=E	144G.71 Subd. 8 Documentation of administration of medication 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	{01760}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01760}	Continued From page 6 with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action needed.	{01760}		
{01900} SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01900}		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: No further action needed.	{02310}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 29, 2023

Licensee
Brookstone Manor
722 North Pokegama Avenue
Grand Rapids, MN 55744

RE: Project Number(s) SL20077015

Dear Licensee:

On November 13, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 24, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 24, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 24, 2023, found not corrected at the time of the November 13, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) = $500.00

The details of the violations noted at the time of this follow-up survey completed on November 13, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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.

IMPOSITION OF FINES:

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.

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.

To submit a reconsideration request, please visit:

https://www.web.health.state.mn.us/form/HRD-Appeals-Form

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 MDH 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://www.web.health.state.mn.us/form/HRD-Appeals-Form**.

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.

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 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
	20077	A. BUILDING: _____ B. WING _____	R 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE MANOR	722 NORTH POKEGAMA AVENUE 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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL20077015-1 On November 13, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 24, 2023. At the time of the survey, there were 38 residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{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.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	{0 510}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 510}	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	{0 650}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 650}	Continued From page 2 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action needed.	{0 650}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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. This MN Requirement is not met as evidenced by: 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. 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 potential to affect a large portion or all of the residents). Findings include:	{0 800}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 800}	Continued From page 3 On a facility tour on November 13, 2023, 11:00 a.m. with and maintenance (M)-C it was observed that the fire-resistant rated door A wing third floor west stairway did not self-close and latch. It was stated by M-C the closer for this door is on order. Fire resistant rated doors are required to automatically close and latch. It was also observed the laundry room door provided with self-closing hinges does not automatically close and latch. It was stated by M-C a closer for the door has been ordered. Doors provided with self-closing devices are required to operate as designed and installed at the time of construction. It was also observed that a hole was cut creating an opening through the fire-resistant rated stairway enclosure in the east A wing stairway and west C wing open stairway. It was observed the membrane on the interior stairway side was repaired but repair of the opening on the other side of wall could not be verified at the time of the tour. Fire-resistant rated stairway and corridor walls are required to be maintained without openings that are not protected as required at the time of construction approval. It was observed that the ceilings in the dining room, east stairway of A wing and west stairway of A wing were damaged by a currently leaking roof. It was stated by M-C the roof repair is underway and the ceilings are scheduled to be repaired. It was also observed that the resident room numbers identifying rooms in the C wing were removed for painting of walls and not replaced as stated by facility maintenance staff. Room	{0 800}		

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{0 800}	Continued From page 4 numbers were written on paper signs and posted at the resident rooms. The room number signs are required to be durable to withstand normal ware and cleaning. Resident room numbers are required to be maintained in place to identify locations of resident rooms based on facility fire safety and evacuation floor plan. It was observed that resident rooms C-108 and C-103 in the lower level of the C wing are vacant, in disrepair and, missing floor covering. Resident rooms are required to be maintained with floor covering and wall finishes as approved at the time of construction. It was also observed that the ceiling was stained, and finish is flaking off in resident room 211. Ceilings are required to be maintained free of stains caused by water or other liquid leaks. These deficient conditions were visually verified by M-C accompanying on the tour.	{0 800}		
{0 900} SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a	{0 900}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 900}	Continued From page 5 complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: No further action needed.	{0 900}		
{01290} SS=E	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	{01290}		

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{01290}	Continued From page 6 liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action needed.	{01290}		
{01760} SS=E	144G.71 Subd. 8 Documentation of administration of medication 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. This MN Requirement is not met as evidenced by: No further action needed.	{01760}		
{01900} SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01900}		

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{02310}	Continued From page 7	{02310}		
{02310} SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: No further action needed.	{02310}		

Electronically Delivered

September 13, 2023

Licensee
Brookstone Manor
722 North Pokegama Avenue
Grand Rapids, MN 55744

RE: Project Number(s) SL20077015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 24, 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.

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 . . ."

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), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The 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. The 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 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

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 MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20077	A. BUILDING: _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE MANOR	722 NORTH POKEGAMA AVENUE 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: SL20077015-0 On August 22, 2023, through August 24, 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 38 active residents; all of 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for two of three employees (unlicensed personnel (ULP)-E, ULP-D) during medication administration. In addition, the licensee failed to ensure one of one employee (ULP-D) disinfected shared equipment between resident use. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: MEDICATION ADMINISTRATION ULP-E On August 23, 2023, at 6:19 a.m., the surveyor observed ULP-E start the medication administration process for R3. At 6:23 a.m., ULP-E donned (put on) gloves, poke R3's finger	0 510		

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0 510	Continued From page 2 and complete a blood glucose reading. With the same gloved hands, ULP-E put on R3's shoes, assisted R3 to the bathroom for toileting, and doffed (removed) gloves. Without performing hand hygiene, ULP-E picked up R3's blood glucose meter, administered R3's medications, check R3's oxygen levels, and then assisted R3 down to the dining room for breakfast. ULP-E returned to the medication cart and without performing hand hygiene, began providing services to another resident(R2). ULP-E scanned R2's Free Style Libre for a blood glucose reading, completed R2's scheduled morning medication, set up R2's medications for 12:00 p.m. when R2 will be out of the facility, documented, and applied hand sanitizer to hands. . On August 23, 2023, at 10:13 a.m., ULP-E stated hand hygiene was not done in between all residents this morning and upon removing gloves. ULP-E further stated hand washing should be done between residents and when gloves are removed. ULP-D On August 23, 2023, at 7:06 a.m., the surveyor observed ULP-D complete medication administration for R6. The surveyor did not observe hand hygiene before or after the medications administration. Immediately following this observation ULP-D went to assist R7. On August 23, 2023, at 7:40 a.m., the surveyor observed ULP-D complete R12's medication set up for when R12 will be out of the facility. The surveyor did not observe ULP-D complete hand hygiene before or after. Immediately following at 7:44 a.m., the surveyor observed ULP-D provide scheduled morning medication administration for R7 including eye drops. ULP-D donned gloves,	0 510		

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0 510	Continued From page 3 placed one drop in each eye, removed gloves, assisted R7 with grooming, and returned to the medication cart. The surveyor did not observe any hand hygiene. On August 23, 2023, at 10:16 a.m., ULP-D stated she did not perform proper hand hygiene in between residents and normally washes hands in between residents. On August 23, 2023, at 1:04 p.m., clinical nurse supervisor (CNS)-B stated hand hygiene should be completed between each resident, prior to staff putting on gloves, and when staff remove gloves. REUSABLE MEDICAL EQUIPMENT On August 23, 2023, at 7:12 a.m., the surveyor observed ULP-D remove an oxygen saturation monitor out of the side of the medication cart without disinfecting the oxygen saturation monitor, go to R7's room, placed the oxygen saturation monitor on R7's finger, obtained the readings, removed it from R7's finger, and placed it back into the side of the medication cart without disinfecting the oxygen saturation monitor. On August 23, 2023, at 8:08 a.m., the surveyor observed ULP-D remove a blood glucose meter out of a plastic box labeled stock out of the medication cart to get a blood glucose reading on R4. ULP-D stated R4's Free Style Libre was not scanning properly and would have to do a finger poke. The surveyor did not observe ULP-D clean the blood glucose meter before using it on R4, placed it back into the plastic box, and then documented in R4's chart. On August 23, 2023, at 10:16 a.m., ULP-D stated the stock blood glucose monitor was not cleaned	0 510		

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0 510	Continued From page 4 before or after it was used on R4 since only R4 used it this morning, however, it could be used for another resident if their blood glucose meter was not working properly. In addition, ULP-D stated shared equipment should be cleaned after every use. On August 23, 2023, at 1:05 p.m., CNS-B stated all shared medical equipment should be disinfected after each use, so it is ready for the next resident. CNS-B further stated staff need to read the disinfectant instructions to allow the correct amount of time the equipment needs to dry. The licensee's 8.17 Hand Washing policy dated September 20, 2021, indicated hand washing shall be completed before and after administering medications to a resident. If, however, hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands. The licensee's 8.15 Gloves policy dated September 20, 2021, indicated hands should be washed before applying gloves and rewash hands after removing gloves. The Centers for Disease Control and Prevention (CDC)'s guidance, Recommended Practices for Preventing Bloodborne Pathogen Transmission during Blood Glucose Monitoring and Insulin Administration in Healthcare Settings, last reviewed March 2, 2011, indicated whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions,	0 510		

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0 510	Continued From page 5 to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	0 650		

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0 650	Continued From page 6 Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on August 22, 2023, at 10:31 a.m., assisted living director in residency (ALDIR)-A stated the licensee was aware of the required contents of the employee records. ULP-D was hired on May 6, 2022, to provide assisted living services. On August 23, 2023, at 7:06 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R6. ULP-D's record lacked the following competency evaluation documentation: -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing; care of teeth, gums and oral prosthetic devices; care and use of hearing aids; and dressing and assisting with toileting; -standby assistance techniques and how to perform them; -reading and recording temperature, pulse, and respirations of the resident;	0 650		

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0 650	Continued From page 7 -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. On August 23, 2023, at 12:39 p.m., ULP-D stated training and competency testing was done for her by a previous registered nurse (RN) at the licensee, but could not recall the exact date. ULP-D further stated the competency testing with the RN was completed prior to working on the floor with residents. On August 23, 2023, at 1:17 p.m., clinical nurse supervisor (CNS)-B stated all ULP employee records should contain the above listed competencies, but they (licensee) were unable to locate ULP-D's competency sign off sheet. On August 23, 2023, at 1:50 p.m., regional director (RD)-F stated the licensee was unable to find ULP-D's competency trainings done by a previous RN. The licensee's 10.04 Competency Training Evaluations policy dated August 1, 2021, indicated a copy of all education, training, and competency testing shall be kept in each team member's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 8 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. This MN Requirement is not met as evidenced by: 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. 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 potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 24, 2023, at approximately 2:30 p.m. with and maintenance (M)-C it was observed that the fire-resistant rated door of A wing second floor west stairway, A wing third floor west stairway, A wing second floor east stairway, A wing first floor east stairway and, A wing first floor west stairway do not self-close and latch. Fire resistant rated doors are required to automatically close and latch. It was also observed the laundry room door provided with self-closing hinges does not	0 800		

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0 800	Continued From page 9 automatically close and latch. Doors provided with self-closing devices are required to operate as designed and installed at the time of construction. It was also observed that the laundry chute door in the lower-level laundry room was provided with a rope and pulley to hold the door open. Fire resistant rated laundry chute doors are required to close and latch unless provided with an approved hold open device. It was also observed that a hole was cut creating an opening through the fire-resistant rated stairway enclosure in the east A wing stairway and west C wing open stairway. Fire-resistant rated stairway and corridor walls are required to be maintained without openings that are not protected for fire resistance as required at the time of construction approval. It was observed that water from a leak was on the floor under the center boiler in the lower-level boiler room. Hot water boiler systems are required to be maintained free of leaks as approved at the time of construction. It was also observed that a bathroom exhaust fan had exposed electrical connections and was plugged into a light socket adapter in the public restroom B-2. Electrical wiring is required to be maintained as approved at the time of installation. It was also observed that an electrical outlet box cover was missing in the activity's storage room. Electrical box covers are required to be maintained in place as approved at the time of installation. It was observed that the ceiling in the dining	0 800		

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0 800	Continued From page 10 room, east stairway of A wing and, west stairway of A wing were damaged by a currently leaking roof. Facility maintenance staff stated roof repair is scheduled. The roof cover is required to be maintained free of leaks as approved at the time of construction. It was also observed that the resident room numbers identifying rooms in the C wing were removed for painting of walls and not replaced as stated by facility maintenance staff. Resident room numbers are required to be maintained in place to identify locations of resident rooms based on facility fire safety and evacuation floor plan. It was observed that the resident rooms in the lower level of the C wing are vacant, in disrepair and, missing floor covering. Resident rooms are required to be maintained with floor covering and wall finishes as approved at the time of construction. It was also observed that the ceiling was stained in the lower level of the C wing corridor, C wing top floor corridor, resident room 211 and A-2 public restroom/ tub room. Ceilings are required to be maintained free of stains caused by water or other liquid leaks. These deficient conditions were visually verified by M-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 11 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents,	0 810		

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BROOKSTONE MANOR	722 NORTH POKEGAMA AVENUE 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
0 810	Continued From page 12 staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on August 24, 2023, at approximately 1:45 p.m. of documents provided by maintenance (M)-C and safety coordinator (SC)-I 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 the licensee did not have detailed unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency available with the fire safety and evacuation plan. Individual unique and unusual needs of each resident for evacuation during a fire or similar emergency is required to be available with the fire safety and evacuation plan in order to help communicate evacuation needs to staff and emergency personnel. Record review of the available documentation indicated that employee training was not documented indicating the required sequence of once at initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Facility fire safety and evacuation plan employee training is required to be documented separately	0 810		

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0 810	Continued From page 13 from drills. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Resident training on the fire safety and evacuation plan for the facility is required to be offered to the residents once annually. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence. Evacuation drills for staff are required to be conducted and documented every other month and twice per year per shift and documented separately from employee training. All deficiencies were verified by M-C and SC-I during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with	0 820		

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0 820	Continued From page 14 a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 24, 2023, at approximately 2:30 p.m. with maintenance (M)-C, it was observed that a gas-powered snow blower and portable gas cans were located in a non-fire-resistant rated room with a door opening into the west exit vestibule near the chapel. Exit paths are required to remain free of combustible liquids and similar materials. It was also observed that a swinging gate was installed in the exit stairway that opened in the opposite direction of egress travel. Exit stairways are required to be maintained free of obstructions that prevent the use of the required exit. This deficient condition was verified by M-C accompanying on the tour.	0 820		

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0 820	Continued From page 15 TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced	0 900		

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0 900	Continued From page 16 by: Based on observation, interview, and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R2's diagnoses included diabetes, hyperlipidemia (high cholesterol), obesity, hypertension (HTN-high blood pressure), and asthma. R2's service plan dated May 15, 2023, indicated the resident received services to include medication administration, blood glucose monitoring, laundry, and light housekeeping. On August 23, 2023, at 6:35 a.m., the surveyor observed unlicensed personnel (ULP)-E conduct a blood glucose check and administer R2's scheduled medications. R2's records lacked evidence that the contract had been fully executed as the facility must: - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated	0 900		

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0 900	Continued From page 17 representative. On August 24, 2023, at 12:59 p.m., regional director (RD)-F stated the licensee did not have a signed assisted living contract for R2 after the new contract was revised in August 2022. The licensee's 1.06 Signing an Assisted Living Contract dated August 1, 2021, indicated when a prospective resident is ready to signa lease and move in the contract will be reviewed, signed, and the original contract will be given to the resident and/or responsible party. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01290 SS=E	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	01290		

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01290	Continued From page 18 by: Based on observation, interview and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter with the correct affiliation for the assisted living facility for three of six employees (unlicensed personnel (ULP)-D, ULP-G, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired May 6, 2022, to provide assisted living services. On August 23, 2023, at 7:06 a.m., the surveyor observed ULP-D provide scheduled morning medication administration to R6. ULP-D's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-G ULP-G was hired November 21, 2019, and had begun to provide assisted living services August 1, 2021. ULP-G's record lacked documentation of a	01290		

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01290	Continued From page 19 cleared background study affiliated with the facility's license. ULP-H ULP-H was hired November 2, 2022, to provide assisted living services. ULP-H's record lacked documentation of a cleared background study affiliated with the facility's license. On August 23, 2023, at 1:52 p.m. through 1:58 p.m., the surveyor reviewed the licensee's Minnesota Department of Human Services NetStudy 2.0 Background Study roster with regional director (RD)-F. RD-F stated the above ULPs were current employees of the licensee, however, the background studies were affiliated with a sister facility and not affiliated with this licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication 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	01760		

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01760	Continued From page 20 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel (ULP)-E) observed administering medications for two of two residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 22, 2023, at 10:36 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents at the facility. R2 R2's diagnoses included diabetes, hyperlipidemia (high cholesterol), obesity, hypertension (HTN-high blood pressure), and asthma. R2's service plan dated May 15, 2023, indicated the resident received services to include	01760		

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01760	Continued From page 21 medication administration six times per day. R2's prescriber orders dated January 27, 2023, included an order for Advair 250-50 micrograms (mcg) inhale 1 puff into the lungs two times a day and rinse mouth after each use. R2's August 2023 electronic medication administration record (EMAR) indicated Advair 250-50 mcg administer inhaler one puff twice per day. On August 23, 2023, at 6:44 a.m., the surveyor observed ULP-E conduct a medication pass for R2. ULP-E handed R2 the Advair inhaler for self-administration and R2 then returned the Advair inhaler back to ULP-E. ULP-E handed R2 her scheduled morning medications with a glass of water, R2 took the medications, and swallowed the water. R5 R5's diagnoses included chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease that causes obstructed airflow from the lungs), and nicotine dependence. R5's Individualized Medication Management Plan dated July 13, 2023, indicated the resident received medication administration services. R5's prescriber orders dated July 10, 2023, included an order for Symbicort 160-4.5 mcg inhale two puffs by mouth every 12 hours as needed for COPD. Rinse mouth with water after use to reduce aftertaste and incidents of candidiasis (fungal infection). No not swallow [sic]. R5's August 2023 EMAR indicated Symbicort	01760		

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01760	Continued From page 22 160-4.5 mcg inhale two puffs by mouth twice daily for COPD. Rinse mouth with water after use to reduce aftertaste and incidents of candidiasis. No not swallow [sic]. On August 23, 2023, at 6:59 a.m., the surveyor observed ULP-E conduct a medication pass for R5. ULP-E handed R5 the Symbicort inhaler for self-administration and R5 then returned the Symbicort inhaler back to ULP-E. ULP-E handed R5 his scheduled morning medications with a glass of water, R5 took the medications, and swallowed the water. On August 23, 2023, at 10:13 a.m., ULP-E stated ULP-E was trained to have residents rinse their mouth after an inhaler administration, so ULP-E completes the inhaler administration first, then the resident can take their oral medications, and rinse their mouth with the water when the oral medications are taken. ULP-E further stated, ULP-E does not offer the resident to spit the water out. On August 23, 2023, at 1:07 p.m., CNS-B stated residents should rinse mouth with water and spit the water out after an inhaler administration if the medication package instructions indicate to do so. The manufacturer's instructions for use of Advair inhaler dated August 2020, indicated to rinse mouth with water after use and spit out the water, do not swallow the water. The manufacturer's instructions for use of Symbicort inhaler dated August 2019, to rinse the mouth with water without swallowing. The licensee's 12.11 Medication Management:	01760		

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01760	Continued From page 23 Administration and Setup policy dated August 1, 2021, indicated the ULP will documents any reason why medication administration was not completed as prescribed and documents any follow-up procedures that were provided to mee the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription drug supply for one of one resident (unknown resident) were not saved for use by anyone other than the resident for which the medication was prescribed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01900		

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01900	Continued From page 24 On August 23, 2023, from 1:09 p.m., through 1:12 p.m., the surveyor toured the employee training room with clinical nurse supervisor (CNS)-B, including a review of the medication cart. The following was observed in the training medication cart: -one full opened bottle of Fortical nasal spray with the pharmacy label mostly removed from the bottle; - 25 unopened albuterol 2.5 milligrams (mg) per 3 milliliters (mL) jets in a box with the pharmacy label mostly removed; and -29 unopened DuoNeb 3 mL jets in a box with the pharmacy label mostly removed. On August 23, 2023, at 1:13 p.m., CNS-B stated the above medications previously had pharmacy labels on them, which would have been used for a specific resident. CNS-B stated she was unable to identify the residents as that information was removed when the label was torn off and was not aware they were in the training medication cart. CNS-B further stated prescription medications should be disposed of and not saved for another use. The licensee's 12.21 Medications: Prescription Drugs and Prohibition policy dated August 1, 2021, indicated no prescription drug supply for one resident may be used or saved for use by anyone other than the original prescribed resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		

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02310	Continued From page 25	02310		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for two of two residents (R3, R6) with a hospital bedrail. This practice resulted in a level two violation (a violation that did not harm a client'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: R3 R3's diagnoses included chronic obstructive pulmonary disease (COPD-chronic inflammatory lung disease that causes obstructed airflow from the lungs), diabetes, and bipolar disorder. On August 23, 2023, at 6:19 a.m., the surveyor observed R3 lying in bed. R3's bed had one upper bedrail in the upright position on the left side of R3's bed with the right side of the bed tight	02310		

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02310	Continued From page 26 up against the wall. R3's Service Plan dated July 7, 2023, indicated R3 required assistance with medication administration, blood glucose checks, housekeeping, and assistance with bathing, grooming, and dressing. R3's Bed Safety Assessment dated July 7, 2023, indicated R3 had an upper half bedrail on R3's bed. R3 used the side rail to assist with transfers and bed mobility. The bed rail did not function as a restraint. R3 was not at risk for injury due to cognition, no previous injury related to bed rails, was not taking any medications that would affect R3's mental status, and risks and benefits of the bedrail was discussed, and understanding was verbalized by R3. In addition, the following was documented: -Zone 1: The area within the rail was less than 4 ¾ inches; -Zone 2: The area under the rail, between the rail supports or next to a single rail support was less than 4 ¾ inches; -Zone 3: The area between the rail and mattress was less than 4 ¾ inches; -Zone 4: The area under the rail, at the ends of the rail was less than 2 3/8 inches and greater than a 60-degree angle at the end of the bed rail relative to the top; -Zone 5: The space between the split bed rails was not applicable as they were only upper rails; Zone 6: The gap between the end of the bed rail and the side edge of the headboard did not present a risk of entrapment of the head, neck, or chest; and Zone 7: There was no large space between the inside surface of the headboard and the end of the mattress that could cause risk of head entrapment.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20077	A. BUILDING: _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE MANOR	722 NORTH POKEGAMA AVENUE 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
02310	Continued From page 27 R3's record lacked a comprehensive assessment on the use of an assistive device to include actual measurements of the entrapment zones. R6 R6's diagnoses included bipolar disorder, hypertension (HTN-high blood pressure), obesity, and chronic left shoulder pain. R6's Service Plan dated May 15, 2023, indicated R6 required assistance with medication assistance, housekeeping, behavioral management, and assistance with bathing. R6's Bed Safety Assessment dated August 7, 2023, indicated R6 had upper half bedrails on R6's bed. R6 used the side rails to assist with bed mobility and transfers. The bed rails do not function as a restraint. R6 was not at risk for injury due to cognition, no previous injury related to bed rails, was not taking any medications that would affect R6's mental status, and risks and benefits of the bedrails was discussed, and understanding was verbalized by R6. In addition, the following was documented: -Zone 1: The area within the rail was less than 4 ¾ inches; -Zone 2: The area under the rail, between the rail supports or next to a single rail support was less than 4 ¾ inches; -Zone 3: The area between the rail and mattress was less than 4 ¾ inches; -Zone 4: The area under the rail, at the ends of the rail was less than 2 3/8 inches and greater than a 60 degree angle at the end of the bed rail relative to the top; R6's record lacked a comprehensive assessment on the use of an assistive device to include actual	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20077	A. BUILDING: _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE MANOR	722 NORTH POKEGAMA AVENUE 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
02310	Continued From page 28 measurements of the entrapment zones. On August 24, 2023, at 1:01 p.m., clinical nurse supervisor (CNS)-B stated R3 and R6 had hospital style bed rails. CNS-B stated CNS-B measured the zones of the bedrails every 90 days, but does not document the actual measurements only answers the questions prompted in the Bed Safety Assessment to indicate CNS-B measurement was less the maximum area in each zone for any resident with a hospital style bed rail. The licensee's 11.29 Side Rails policy dated July 27, 2023, indicated the side rail design is consistent with the FDA's (Food and Drug Administration) 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1, 2, and 3 must not exceed 4 ¾ inches. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated August 7, 2023, "Documentation about a resident's bed rails includes, but is not limited to:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20077	A. BUILDING: _____ B. WING _____	08/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE MANOR	722 NORTH POKEGAMA AVENUE GRAND RAPIDS, MN 55744

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02310	Continued From page 29 - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *08/23/23*
Time: 11:54:20
Report: 7939231146

Food and Beverage Establishment Inspection Report

Location:
Brookstone Manor
722 North Pokegama Avenue
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:
ID #: 0039365
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2183265339
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 200PPM at Degrees Fahrenheit
Location: RAG BUCKET
Violation Issued: No

Chlorine: = 50PPM at Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BURGER
Temperature: 167 Degrees Fahrenheit - Location: COOKING
Violation Issued: No

Process/Item: BUTTER
Temperature: 40 Degrees Fahrenheit - Location: 2 DOOR FRIDGE
Violation Issued: No

Process/Item: SOUP
Temperature: 39 Degrees Fahrenheit - Location: WALK-IN
Violation Issued: No

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

DISCUSSION
SAMANTHA HAS PASSED HER SERVESAFE COURSE BUT HAS NOT APPLIED WITH THE STATE. SHE WAS FILLING OUT THE APPLICATION AS I LEFT AND WILL MAIL IT IN.

ONLY BLEACH AND WATER IN THE RAG BUCKET, NO SOAP

Food and Beverage Establishment Inspection Report

GREAT GOLVE USE AND HAND WASHING OBSERVED

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 7939231146 of 08/23/23.

Certified Food Protection Manager:_____

Certification Number: APPLIED Expires: / /

Signed: NA

SAMANTHA ADAMS
CFPM

Signed: _____

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