Electronically Delivered
May 20, 2024

Licensee
Pleasant View Estates, LLC
41 Brand Avenue
Faribault, MN 55021

RE: Project Number(s) SL30553015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 1, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

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

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

If you have any questions, please contact me.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30553	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW ESTATES LLC	41 BRAND AVENUE FARIBAULT, MN 55021

(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: SL30553015 On April 29, 2024, through May 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 36 residents; 33 receiving services under the provider's 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by a registered nurse at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 470		

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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's census was 36 residents, 33 of whom currently received services under the assisted living license. During the entrance conference on April 29, 2024, at 10:45 a.m., the surveyor requested a staffing plan. Licensed assisted living director/registered nurse (LALD/RN)-A stated the staff schedule/staffing plan was posted near the front entrance of the facility. At 11:29 a.m. during the facility tour with assisted living director designee (ALDD)-B, the surveyor observed the Two Day Staffing Plan dated April 29, 2024, and April 30, 2024, posted near the front entrance of the building. The posting included the hours worked for each shift and first name of each staff working those hours. On May 1, 2024, at 1:32 p.m. LALD/RN-A emailed the surveyor a copy of the Staffing Plan. The document attached to the email was the licensee's Staffing Policy which included a section titled, Facility, with a grid to fill in the following information: Date; Review Period; Average Billable Hours/day; Staffing Plan Hours; Scheduled Hours; and Payroll Hours. The grid had been filled out with the following information: Date: 4/1/24 Review Period: 3/1/24 - 3/31/24 Average Billable Hours/day: 83.68 Staffing Plan Hours: 55.77	0 470		

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0 470	Continued From page 3 Scheduled Hours: 40 Payroll Hours: 32 Below this section was a comments sections that indicated: NOC (night): 8 hours Hskp (housekeeping): 8 hours The document was signed by a RN and ALDD-B The staffing plan document did not include clear direction of the following criteria: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions. On May 1, 2024, at 3:19 p.m. ALDD-B reviewed the provided staffing plan and was unable to interpret the content related to the above required	0 470		

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0 470	Continued From page 4 criteria. The licensee's Staffing Policy last reviewed April 1, 2024, indicated: The licensee will develop and implement a staffing plan for determining a staffing level that: Includes an evaluation, to be completed at least twice annually, of the appropriateness of staffing levels in the facility. Ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hours per day basis including 24-hour awake staff. Ensures that the facility can respond promptly and effectively to the individual resident, emergencies and to emergencies, life safety and disaster situations affecting staff or residents in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was	0 480		

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0 480	Continued From page 5 prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of	0 550		

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0 550	Continued From page 6 Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 29, 2024, at 11:29 a.m. the surveyor toured the facility with licensed assisted living director designee (ALDD)-B and licensed practical nurse (LPN)-C. There were postings by the front entrance that included the grievance procedure, but did not include contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. ALDD-B reviewed the grievance procedure posting and stated it did not include the required ombudsman contact information nor was that information posted elsewhere in the facility.	0 550		

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0 550	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
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: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two employees (unlicensed personnel (ULP)-F and ULP-G).	0 650		

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0 650	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F ULP-F started employment on February 13, 2023. On April 30, 2024, at 7:48 a.m. ULP-F was observed to administer medications to R5. ULP-G ULP-G started employment on April 21, 2021. On April 30, 2024, at 11:20 a.m. ULP-G was observed administering insulin to R6. ULP-F and ULP-G's records lacked an annual performance review that identified areas of improvement needed and training needs. On May 1, 2024, at 1:55 p.m. the surveyor received an email from licensed assisted living director/registered nurse (LALD/RN)-A indicating the above employee annual performance reviews had not been completed. The licensee's Personnel Files/Employee Records policy dated November 2019, indicated: The employee file shall contain: q. Documentation of annual performance review, which identify areas of improvement and	0 650		

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0 650	Continued From page 9 training recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-F).	0 660		

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0 660	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated November 2, 2023, indicated the licensee was a low risk. On April 30, 2024, at 7:48 a.m. ULP-F was observed administering medications to R5. ULP-F's employee record showed ULP-F had a start date of February 13, 2023. ULP-F's employee's record contained a TB Baseline Screening Tool for Health Care Workers form dated February 13, 2023. The form indicated ULP-F had a first-step TST administered on April 13, 2023, and read on April 16, 2023. The form did not include evidence that a second step TST had been completed. On May 1, 2024, at 1:55 p.m. the surveyor received an email from licensed assisted living director/registered nurse (LALD/RN)-A indicating the above employee second-step TST had not been completed. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health	0 660		

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0 660	Continued From page 11 Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (health care workers) (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). The 2-step TST identified as: Procedure used for the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term-care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1-3 weeks after the first TST result was read. If the second TST result is positive, it probably represents a boosted reaction, indicating infection most likely occurred in the past and not recently. If the second TST result is also negative, the person is classified as not infected. The licensee's Tuberculosis & Staff Screening policy dated January 2020, indicated: Screening shall be conducted as follows: 1. New staff shall be screened for active signs of TB using the Baseline TB Screening Tool for HCWs 2. New staff shall have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs	0 660		

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0 660	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required	0 680		

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	30553	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW ESTATES LLC	41 BRAND AVENUE FARIBAULT, MN 55021

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0 680	Continued From page 13 content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's emergency preparedness plan last reviewed January 4, 2023, lacked the following required content: - Emergency prep testing requirements On May 1, 2024, at 3:19 p.m. assisted living director designee (ALDD)-B stated being unable to find evidence of emergency prep testing requirements other than fire drills. ALDD-B further stated being unaware of the requirement. The licensee's Emergency Preparedness Plan last reviewed November 13, 2023, indicated: Annually, the licensee management staff will participate in a full-scale exercise that is community-based, or when a community-based exercise is not accessible, an individual, facility-based tabletop exercise. Community-based exercises will generally be done in coordination with our Regional Health Care Preparedness Coordinator. If a community-based full-scale exercise is not available, the facility will document their attempt to participate in one (document personnel or agencies contacted and reasons for inability to	0 680		

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0 680	Continued From page 14 participate) and replace it with a table-top exercise. If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for one year following the onset of the actual event. The facility will also conduct an additional annual exercise that may include, but is not limited to the following: A second full-scale exercise that is community-based or individual, facility based; or" A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinical relevant emergency scenario, and a set of problem statements, directed message, or prepared questions designed to challenge an emergency plan; or; A mock disaster drill. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install two portable fire extinguishers as required by statute. 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, 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: On April 29, 2024, at 12:20 p.m., survey staff toured the facility with assisted living director designee (ALDD)-B, maintenance assistant (MA)-D, and regional maintenance director (RMD)-E. During the tour, survey staff observed two portable fire extinguishers stored on the floor in the mechanical room on the first floor. Fire extinguishers must be available in an emergency and properly installed to prevent them from being moved or damaged. On April 29, 2024, during the facility tour interview, MA-D stated they did not know why the fire extinguishers were stored on the floor. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800	Continued From page 16	0 800		
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 provide the physical environment in a continuous state of good repair and operation with regard to 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 the potential to affect a large portion or all of the residents). The findings include: On April 29, 2024, at 12:20 p.m., survey staff toured the facility with assisted living director designee (ALDD)-B, maintenance assistant (MA)-D, and regional maintenance director (RMD)-E. During the tour, survey staff observed the following: 1. a. The door closer arms were missing on the labeled 20-minute fire doors leading from the	0 800		

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0 800	Continued From page 17 corridor into resident dwelling units 312, 309, 306, 301, 214, 213, 211, 210, 209, 206, 202, 201, 107 and 103. b. The door closer arm was missing on the labeled 20-minute fire door for the third-floor storage room adjacent to resident dwelling unit 309A. These fire doors did not self-close and positively latch. All components of a fire door assembly must be maintained in proper working order. On April 29, 2024, during the facility tour interview, ALDD-B, MA-D, and RMD-E verified the door closer arms had been removed from these fire doors. 2. The electromagnetic door holder for the labeled 20-minute fire door was not working in the third-floor therapy room, the magnet on the fire door was missing. Electromagnetic door holders must be maintained as designed to hold open self-closing fire doors until released by the fire protection system. This fire door was being held open by a magnetic door catch not connected to the existing fire alarm system in the building. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. On April 29, 2024, during the facility tour interview, MA-D and RMD-E verified this fire door was not properly maintained. 3. In the craft room on the second floor, a power strip was plugged into a multiplug adapter. In the dining room, a power strip was plugged into an extension cord and an extension cord was plugged into a multiplug adapter. The improper use of extension cords, multiplug adapters, and power strips creates a potential fire hazard. On April 29, 2024, during the facility tour interview, MA-D and RMD-E stated they were not aware of these electrical connections. 4. On April 29, 2024, ALDD-B provided the annual fire alarm and signaling inspection report dated	0 800		

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0 800	Continued From page 18 November 6, 2023. Three dampers failed the functional test. During the facility tour interview on April 29, 2024, ALDD-B stated the dampers did not work. During an interview on April 29, 2024, at 4:30 p.m., ALDD-B stated replacement dampers were on order. 5. The exit sign was not illuminated at the end of the corridor on the first floor near the electrical room. On April 29, 2024, during the facility tour interview, RMD-E verified the exit sign was not illuminated. 6. Magnetic door catches not connected to the existing fire alarm system in the building were installed on labeled fire doors for the activities room and mechanical room on the first floor. On April 29, 2024, during the facility tour interview, MA-D and RMD-E verified the improper use of these door catches. 7. In the mechanical room across from the boiler room on the first floor: a. There was a hole in the ceiling and fire caulking missing around the air ducts. b. There were two holes in the wall behind the door. c. A hose was installed on the utility sink threaded faucet with the end of the hose located below the flood-level rim of this sink. A backflow prevention device was not installed on this water supply line. On April 29, 2024, during the facility tour interview, MA-D and RMD-E verified the holes and missing fire caulking. RMD-E stated the utility sink required a backflow prevention device. 8. The listed fire doors did not positively latch for the first-floor laundry and electrical rooms. Fire caulking was missing at the wall to ceiling transition in the electrical room. On April 29, 2024, during the facility tour interview, MA-D verified these doors did not latch properly and fire caulking was missing. 9. Ceiling tiles were water-stained on the first	0 800		

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0 800	Continued From page 19 floor in the corridor outside the mechanical room, in the dining room, activities room, and storage room next to the elevator. On April 29, 2024, during the facility tour interview, RMD-E stated they did not know why the ceiling tiles were water-stained. 10. The electrical wall outlet was loose in the corridor outside resident apartment 209. On April 29, 2024, during the facility tour interview, MA-D and RMD-E verified the loose electrical outlet. 11. In the dining room, covers were missing on fluorescent light fixtures and baseboard heater covers were loose. On April 29, 2024, during the facility tour interview, MA-D and RMD-E verified the missing light covers and loose baseboard heater covers. 12. By the sprinkler room, soffit was missing in several locations on the exterior of the building. The siding was loose on the south side of the building and one vent cover was dented on the north side by the front entrance. 13. In the garage used for resident parking, several pieces of exterior siding were missing. On April 29, 2024, during the facility tour interview, MA-D verified the missing soffit and siding, loose siding, and dented vent cover and stated these items required repair. Resident Dwelling Units: 1. In resident room 103, exposed electrical wires with wire nuts were observed adjacent to the light fixture above the kitchen sink. Electrical wires must be properly installed. MA-D and RMD-E stated they had not known before the tour that these wires were exposed and stated this required repair. Additionally, a light-duty extension cord was being used in this dwelling unit and floor guides were missing for the sliding closet door in the bedroom. MA-D verified the extension cord was used improperly and stated the floor guides	0 800		

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0 800	Continued From page 20 had not been reinstalled after new flooring was installed. 2. In resident room 209, burn marks were observed on the electrical wall outlet in the kitchen, and baseboard heater covers were not installed in the living room. On April 29, 2024, during the facility tour interview, MA-D and RMD-E stated they did not know why the heater covers were missing and verified the burn marks on the wall outlet. 4. In resident room 213, the light fixture cover was missing in the bedroom closet and a power strip was plugged into a multiplug adapter. On April 29, 2024, during the facility tour interview, MA-D stated they did not know why the light cover was missing and verified the improper use of the multiplug adapter and power strip. 3. In resident room 211, the baseboard heater cover had been slid out of place and a window blind cord was draped over the heater. 5. In resident room 301, the TV cable was draped on and between the baseboard heater and cover. 6. In resident room 306, the corner piece and cover for the baseboard heater were lying on the floor next to the heater. On April 29, 2024, during the facility tour interview, MA-D and RMD-E verified the baseboard heaters had not been properly maintained. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 21 (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 develop a fire safety and evacuation plan with the required content and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 22 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). The findings include: On April 29, 2024, the assisted living director designee (ALDD)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included a fire policy dated August 1, 2022. The fire policy was not developed for the facility location and failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. During an interview on April 29, 2024, at 4:30 p.m., ALDD-B stated the FSEP was a generic Monarch template and verified the plan required revision.	0 810		

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0 810	Continued From page 23 TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by a review of employee training records. Employee FSEP training records dated November 22, 2023, and February 20, 2024, were provided for review. During an interview on April 29, 2024, at 4:30 p.m., ALDD-B verified no additional FSEP employee training records were available and stated a FSEP employee training was scheduled for May 2024. DRILLS Record review indicated the licensee failed to conduct employee evacuation drills at a frequency of twice per year per shift with at least one evacuation drill every other month as evident by a review of completed fire drill reports. Three fire drills were recorded in 2023, and one fire drill was recorded in 2024. During an interview on April 29, 2024, at 4:30 p.m., ALDD-B verified the licensee had not met the evacuation drill frequency requirement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics	01530		

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01530	Continued From page 24 related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-F) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01530		

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01530	Continued From page 25 The licensee provided services under an Assisted Living license. ULP-F was hired on February 13, 2023, to provide direct care services to the licensee's residents. ULP-F's employee record contained evidence the employee received five hours and 30 minutes of dementia care training, not at least eight hours of training within 160 working hours of the employment start date as required. On May 1, 2024, at 1:55 p.m. the surveyor received an email from licensed assisted living director/registered nurse (LALD/RN)-A indicating ULP-F had not completed the required eight hours of dementia training. The licensee's Dementia Training Disclosure, undated, indicated: All staff receive 8 hours of training initially within their first 160 hours worked. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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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
01620	Continued From page 26 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 calendar days from the last assessment for one of three residents (R1), failed to conduct a change of condition assessment following hospitalization for one of one resident (R1), and failed to conduct a follow-up assessment within 14 days of admission 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30553	A. BUILDING: _____ B. WING _____	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLEASANT VIEW ESTATES LLC	41 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 27 The findings include: R1 R1's service plan signed April 5, 2024, indicated R1 received services which included medication administration, activities of daily living reminders, behavior monitoring, laundry, and housekeeping. R1's last three assessments were requested. Assessments dated September 15, 2023, December 15, 2023, and March 15, 2024, were provided. 91 days had passed between the September and December 2023 assessments (one day late), and also between the December 2023, and March 2024 assessments (one day late). R1's progress notes indicated R1 had been hospitalized on April 2, 2024, and returned to the licensee on April 11, 2024. R1's medical record did not include a change of condition assessment upon return from hospitalization. R2 R2 was admitted to the assisted living facility on October 1, 2023, with diagnoses including type II diabetes and heart disease. R2's R2's service plan signed April 8, 2024, indicated R2 received services which included medication administration, blood sugar checks, bathing, laundry, and housekeeping. R2's assessments were requested. R2's initial assessment was completed on October 1, 2023 (day of admission). R2's next assessment was completed on October 16, 2023 (15 days after	01620		

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	30553	A. BUILDING: _____ B. WING _____	05/01/2024

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PLEASANT VIEW ESTATES LLC	41 BRAND AVENUE FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 28 admission, or one day late). On May 1, 2024, at 11:50 a.m. licensed assisted living director/registered nurse (LALD/RN)-A reviewed R1's record and could not find evidence of a change of condition assessment following hospitalization. LALD/RN-A further stated R1's last two assessments had been completed late. LALD/RN-A also reviewed R2's assessments and stated the 14-day assessment had been completed late. The licensee's contract utilized for all residents included the following: 14.1 Assessment and Monitoring An individualized initial assessment will be conducted in person by a Registered Nurse prior to the date on which the Resident executes a contract with Provider or on the date the Resident moves in, whichever is earlier. A Registered Nurse, or a Licensed Practical Nurse under the direction of a Registered Nurse, will review and monitor all health-related services provided to the Resident within fourteen (14) days of admission and at least every ninety (90) days thereafter, or more frequently if indicted by a nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.	01640		

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01640	Continued From page 29 (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included end stage renal disease	01640		

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01640	Continued From page 30 and type II diabetes with diabetic neuropathy. R1's progress note dated April 11, 2024, at 2.25 p.m. indicated R1 returned to the facility following hospitalization. The progress note included an order for daily dressing changes to right second toe with antibiotic ointment and band aid. R1's progress note dated April 16, 2024, at 3:08 p.m. indicated a new order to start Epsom salt soaks to bilateral feet three times weekly. R1's medication administration record (MAR) dated April 2024, included the above treatment orders. R1's service plan dated April 5, 2024, did not include the daily wound care treatment to R1's right second toe or the Epsom salt soaks three times weekly to R1's bilateral feet. On May 1, 2024, at 11:50 a.m. licensed assisted living director/registered nurse (LALD/RN)-A reviewed R1's service plan and stated it did not include the wound treatment or Epsom salt soaks and should have been revised. The licensee's Service Plan Policy revised August 1, 2021, indicated: Service Plans 3. The Service Plan must be revised, if needed, based on the results of required tenant monitoring and/or reassessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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01940	Continued From page 31	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R1).	01940		

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01940	Continued From page 32 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 29, 2024, at 10:45 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided treatment management services to residents including simple wound care. R1's diagnoses included end stage renal disease and type II diabetes with diabetic neuropathy. R1's progress note dated April 11, 2024, at 2.25 p.m. indicated R1 returned to the facility following hospitalization. The progress note included an order for daily dressing changes to right second toe with antibiotic ointment and band aid. R1's progress note dated April 16, 2024, at 3:08 p.m. indicated a new order to start Epsom salt soaks to bilateral feet three times weekly. R1's medication administration record (MAR) dated April 2024, included the above treatment orders, although it did not include direction to staff of when to notify a nurse when problems arose with the resident's right second toe wound or bilateral feet.	01940		

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01940	Continued From page 33 On May 1, 2024, at 11:50 a.m. LALD/RN-A reviewed R1's record and stated it did not include direction to staff of when to notify a nurse when problems arose with the resident's right second toe wound or bilateral feet. The licensee's Development of the Individualized Medication, Treatment and Therapy Management Plan and Individualized Medication and Treatment Record policy dated November 2019, indicated: 1) Following completed [sic] of the nursing assessment, including an assessment of the client's need for medication, treatment or therapy management, the RN develops individualized plans for the client in conjunction with the client and/or the client's representative. The plans will address: f) Procedure for staff to notify the RN when there is a problem with any medication management service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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	02310		

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02310	Continued From page 34 services were provided according to acceptable health care and medical, or nursing standards related to oxygen storage. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 29, 2024, at 12:20 p.m., survey staff toured the facility with assisted living director designee (ALDD)-B. During the tour, survey staff observed oxygen cylinders improperly stored in the attached garage. Oxygen cylinders must be stored in areas designated for that use. Several of these oxygen cylinders were loosely stored on the garage floor and had not been placed in racks or secure holders. Oxygen cylinders must be stored upright and firmly secured to prevent them from falling or being knocked over. During the facility tour interview, ALDD-B stated they did not know why these oxygen cylinders were stored here and had not been aware of this before the facility tour. The licensee's Oxygen Policy dated November 2019, indicated: 3. Keep oxygen cylinders and vessels in a well-ventilated area (not in closets, behind curtains, or other confined space). The small amount of oxygen gas that is continually vented from these units can accumulate in a confined space and become a fire hazard.	02310		

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02310	Continued From page 35 4. Oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location. Minnesota Department of Health's Oxygen Cylinder Storage Requirements document dated April 16, 2020, noted the cylinders must be secured with chains or racks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of three residents (R5) observed during medication administration. 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	02320		

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02320	Continued From page 36 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: R5's diagnoses included asthma and chronic obstructive pulmonary disease (COPD). R5's service plan dated April 4, 2024, indicated R1 received medication administration. R5's medication administration record (MAR) dated April 2024, included an order for Breo Ellipta inhaler 100-25, inhale one puff once daily in the morning. Rinse after use. On April 30, 2023, at 7:48 a.m. unlicensed personnel (ULP)-F was observed administering medications to R5. ULP-F entered R5's apartment with the resident's prescribed medications then stated she needed to retrieve a larger medication cup for R5's crushed meds. Prior to doing this, ULP-F handed R5 her Breo Ellipta inhaler to utilize. R5 accepted the inhaler, administered independently, then handed back to ULP-F. ULP-F then exited R5's apartment with the resident's oral medications, then returned with a larger medication cup. ULP-F poured R5's crushed medications into the larger med cup then at R5's request, ULP-F added a small amount of soda to the crushed medications and R5 ingested them. ULP-F did not prompt or provide the resident water to rinse her mouth after administering the inhaler or prior to taking oral medications. At 8:00 a.m., ULP-F stated she had not prompted R5 to rinse her mouth after utilizing her inhaler or provide water to do so.	02320		

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02320	Continued From page 37 On May 1, 2024, at 11:50 a.m. licensed assisted living director/registered nurse (LALD/RN)-A stated would expect staff to prompt R5 to rinse mouth after inhaler use and further stated this was part of the competency testing. ULP-F's medication competency for meter dose inhaler, signed by the RN on April 18, 2023, included: 11. Assist the client, if necessary, to rinse mouth with cup of water and to spit into empty cup or emesis basin (*Required if administering steroidal inhalers). The manufacturer's Breo Ellipta Instructions for Use dated May 2023, indicated: Step 6. Rinse your mouth with water after you have used the inhaler and spit the water out. Do not swallow the water. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza, Se 2105
Mankato, MN

Type: Full
Date: *04/29/24*
Time: 12:34:44
Report: 1028241056

Food and Beverage Establishment Inspection Report

Location:
Pleasant View Estates Llc
41 Brand Avenue
Faribault, MN55021
Rice County, 66

Establishment Info:
ID #: 0037590
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072031024
ID #:

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

The following orders were issued during this inspection.

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Discontinue storing leftovers in the white, domestic refrigerator that does not meet certification for sanitation by ANSI. All leftovers must be held in an approved commercial refrigerator, of which this facility has several.

Comply By: 04/30/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

The container of detergent attached to the dish machine was nearly empty. Ensure that the detergent container is replaced prior to being completely empty.

Comply By: 04/30/24

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: -5 Degrees Fahrenheit - Location: Horizon - Ambient
Violation Issued: No

Type: Full
Date: *04/29/24*
Time: 12:34:44
Report: 1028241056
Pleasant View Estates Llc

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: -10 Degrees Fahrenheit - Location: Beverage Air - Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -10 Degrees Fahrenheit - Location: Beverage AIr - Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: Sliced Tomatoes
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: Arctic Air - Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: Sliced Tomatoes
Violation Issued: No

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

This Inspection was conducted in conjunction with a survey by the Health Regulation Division.

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 1028241056 of 04/29/24.

Certified Food Protection Manager: Debra Lynn

Certification Number: FM21327 Expires: 10/11/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Debra Lynn
Culinary Director

Signed: _____

Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us