



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 3, 2024

Licensee
Cannon Falls Assisted Living
900 Main Street West
Cannon Falls, MN 55009

RE: Project Number(s) SL26730015

Dear Licensee:

On October 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 23, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Jodi Johnson', with a long horizontal flourish extending to the right.

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 13, 2024

Licensee

Cannon Falls Assisted Living

900 Main Street West

Cannon Falls, MN 55009

RE: Project Number(s) SL26730015

Dear Licensee:

On August 15, 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 May 23, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 23, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 23, 2024, found not corrected at the time of the August 15, 2024, follow-up survey and/or subject to penalty assessment are as follows:

1290 - Background Studies Required - 144g.60 Subdivision 1 - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on August 15, 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 \$3,000.00**. 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.

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 Jodi Johnson at 507-344-2730.

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,



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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/15/2024
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
(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: SL26730015-1 On August 12, 2024, through August 15, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 23, 2024. At the time of the survey, there were 92 residents; 63 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, 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 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.		
{01290} SS=I	144G.60 Subdivision 1 Background studies required	{01290}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{01290}	Continued From page 1 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure management of NETStudy 2.0 (web-based system used to submit background study (BGS) requests to the Department of Human Services (DHS) affiliated with the licensee's health facility identification number (HFID) 26730 for one of 78 employees (clinical nurse specialist (CNS)-B). This has the potential to affect all residents residing within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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:	{01290}			

Minnesota Department of Health

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{01290}	Continued From page 2 CNS-B was hired on November 1, 2022, to provide direct care services to residents and supervise unlicensed professionals (ULP) as the licensee's Director of Wellness. On August 13, 2024, at 8:34 a.m. the surveyor reviewed the licensee's NETStudy 2.0 roster for HFID 26730 and compared it with the licensee's current staff roster. The NETStudy 2.0 roster indicated CNS-B's BGS was affiliated with the licensee and indicated CNS-B was not eligible. The supervision column of the roster indicated CNS-B should be removed. On August 13, 2024, at 9:26 a.m. licensed assisted living director (LALD)-A indicated CNS-B was working independently with residents at the facility. On August 13, 2024, at 10:09 a.m. the surveyor received documentation emails for the survey from CNS-B. On July 8, 2024, DHS issued a notice of background study disqualification letter to the licensee regarding CNS-B. The letter indicated the license must immediately remove CNS-B from any position with direct contact, or access to people receiving services pending a possible reconsideration decision. The licensee's 4.02 Background Studies policy dated June 2021, indicated background study results showing an individual that is disqualified from any position allowing direct contact with or access to people receiving services will not be employed by the licensee. No further information was provided.	{01290}			

Minnesota Department of Health

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 21, 2024

Licensee

Cannon Falls Assisted Living

900 Main Street West

Cannon Falls, MN 55009

RE: Project Number(s) SL26730015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 23, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

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

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2024
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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: SL26730015 On May 20, 2024, through May 23, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 94 residents; 63 receiving services under the provider's Assisted Living/with Dementia Care license. 1290: An immediate order was issued on May 21, 2024, at a level 3/Widespread (I). The immediacy was lifted on May 22, 2024; however, the deficiency remains at a level I. 2310: An immediate order was issued on May 21, 2024, at a level 3/Isolated (G). The immediacy was lifted on May 22, 2024; however, the deficiency remains at a level G.	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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1	0 480			
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 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 May 22, 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			
0 650 SS=F	144G.42 Subd. 8 Employee records	0 650			

Minnesota Department of Health

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0 650	Continued From page 2 (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 contained required documentation of completed competencies and training for one of one employee (unlicensed personnel (ULP)-C). 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	0 650			

Minnesota Department of Health

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0 650	Continued From page 3 of the residents). The findings include: ULP-C was hired on December 19, 2022, to provide direct cares to residents. ULP-C's employee record lacked evidence competencies were completed for the following topics: -standby assistance techniques and how to perform them; and -range of motion. ULP-C's employee record also lacked evidence they were trained to prepare residents medications for unplanned times away from the facility. On May 20-22, 2024, the surveyor observed ULP-C perform medication administration and training a newly hired employee. On May 22, 2024, at 10:40 a.m. licensed assisted living director (LALD)-A stated the requested competencies and unplanned times away training for ULP-C were either not completed or were not documented. Clinical nurse supervisor (CNS)-B stated ULP-C had completed the above mentioned competencies but must not have been documented. On May 22, 2024, at 12:21 p.m., ULP-C stated they did receive training for preparing medication for unplanned times away and was able to tell the surveyor the procedure. ULP-C stated they received competency training for standby assistance techniques and range of motion. On May 22, 2024, at 3:23 p.m., CNS-B stated	0 650			

Minnesota Department of Health

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0 650	Continued From page 4 preparing medication for unplanned times away training was being completed for all ULP, but it wasn't being documented. The licensee's 5.10 Training Records policy indicated: "[Licensee name] will document the following information for each competency evaluation, training, retraining, and orientation topic: 1. Facility name, location, and license number 2. Name of the training topic or training program 3. The training methodology, such as classroom style, web-based training, video, or one-to-one training 4. Date of the training and the competency evaluation, and the total amount of time of the training and competency evaluation 5. Name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation, and 6. Name and title of the staff person completing the training, and the staff person's signature with a statement attesting that the staff person successfully completed the training as described in the training documentation. 7. Documentation of the completed competency evaluation, training, retraining, or orientation will be provided to the employee at the time the evaluation or training is completed." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
(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
0 660	Continued From page 5	0 660			
0 660 SS=F	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 interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment. 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:	0 660			

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0 660	Continued From page 6 On May 21, 2024, at 8:14 a.m., licensed assisted living director (LALD)-A stated she was aware of the requirement for TB but did not have a current TB risk assessment. LALD-A provided the facility's TB risk assessment that was completed after the start of the survey. The licensee's Tuberculosis Screening Policy dated June 2021, indicated the facility will maintain a current community TB risk assessment. The assessment will be updated annually, using the data and form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	0 780			

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0 780	Continued From page 7 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to install smoke alarms that complied with fire protection requirements. 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 a facility tour on May 22, 2024, at 11:00 a.m., with the Director of Maintenance (DOM)-I, the surveyor observed the following: Smoke Alarms: During the tour it was observed that smoke alarms outside of the 3rd floor guest bedroom and outside the 206 pod were not present. Survey staff explained to the DOM-I, that all bedrooms and rooms outside the bedrooms in a state-licensed facility shall have a smoke alarm present and they must be interconnected. During the facility tour interview on May 22, 2024,	0 780			

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0 780	Continued From page 8 at 11:00 a.m., DOM-I verified smoke alarms were not installed outside these sleeping rooms. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 800			

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0 800	Continued From page 9 On a facility tour on May 22, 2024, at 11:00 a.m., with the Director of Maintenance (DOM)-I, the surveyor made the following observations of facility hazards and disrepair: Fire Doors: During the tour, survey staff observed several fire doors that were propped open, had the closure removed or had a device holding them open. All doors to the corridors or stairwells shall close and latch under their own power. Several resident room doors were propped open. The chapel, craft, and community rooms had their closures removed. Second floor janitor/electrical room door failed to close and latch. The door from pod 107 did not close and latch and the door handle came apart when turned. Survey staff explained to the DOM-I, that all doors in a state-licensed facility must meet the minimum standards for fire doors and the fire rating shall be maintained at all times. During the facility tour interview on May 22, 2024, at 11:00 a.m., DOM-I verified these fire doors were not maintained. Extension Cords/Power Taps: During the tour it was observed that extension cords were being used permanently. In the following locations extension cords were observed being used: White extension cord to microwave and an extension cord to refrigerator, 4th floor staff breakroom. White extension cord to the time clock, 1st floor kitchen. Green extension cord in the IT server room. White extension cord to temperature screen/hand sanitizer station at the front door. Extension cord in campus director office. Green extension cords in the maintenance shop and in the garage for a fluorescent light fixture. Yellow extension cord to the steamer in the dining room, this cord end showed signs of	0 800			

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0 800	Continued From page 10 overheating. In the following locations power taps were observed being used improperly: RA office 4th floor, (2) refrigerators plugged into one power tap. Office 1st floor where the printer was located, the power taps were daisy chained together and there was a refrigerator and microwave plugged into one of them. Survey staff explained to the DOM-I, that all extension cords and power taps shall be used per the manufacture listing. During the facility tour interview on May 22, 2024, at 11:00 a.m., DOM-I verified the improper use of extension cords and power taps. Emergency/Exit Lights: During the tour it was observed the following exit/emergency lights failed to operate when push button tested: 1st floor from parking garage in stairwell exit/emergency light. Parking garage break/mechanical/electrical room the emergency light failed to operate when push button tested. NE and NW stairwell exit doors, the outside emergency lights failed to operate when push button tested. Survey staff explained to the DOM-I, that all emergency/exit lights shall operate when push button tested and be maintained in operating condition at all times. During the facility tour interview on May 22, 2024, at 11:00 a.m., DOM-I verified these emergency/exit lights did not work. Fire Sprinkler System: During the tour it was observed that there was a light hanging off the fire sprinkler piping in the guest garage. Survey staff explained to the DOMI, that nothing shall be attached to the fire sprinkler system piping. During the facility tour interview on May 22, 2024, at 11:00 a.m., DOM-I verified the	0 800			

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0 800	Continued From page 11 improper light fixture installation. Propane Tank Storage: During the tour it was observed that there were several 20 pound propane cylinders stored inside. Survey staff explained to the DOMI, that all large propane cylinders shall be stored outside of the building. Fire Rating: During the tour it was observed that there was a hole in the wall in the furnace room in the chapel/community room. Survey staff explained to the DOMI, that all fire rated walls shall be kept intact. During the facility tour interview on May 22, 2024, at 11:00 a.m., DOM-I verified the improper propane cylinder storage and hole in the furnace room wall. Laundry Room Utility Sinks: In the 3rd and 4th floor laundry rooms, hoses were installed on the utility sink threaded water faucets with the end of the hoses located below the flood-level rims of the sinks. Backflow prevention devices were not installed on these water supply lines. On May 22, 2024, during the facility tour interview, DOM-I verified the hose installations and confirmed that backflow prevention devices were not installed. 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	0 810			

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0 810	Continued From page 12 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 provide required resident training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 810			

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0 810	Continued From page 13 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 May 22, 2024, director of maintenance (DOM)-I provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year as evident by the lack of documentation to support this had been completed. No training records were provided. During an interview on May 22, 2024, at 3:30 p.m., DOM-I, verified training records were not available and stated residents were trained during the town hall meetings but this had not been recorded. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060			

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01060	Continued From page 14 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01060			

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01060	Continued From page 15 review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R5) who was hospitalized. 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: R5 began receiving services on November 1, 2022, with a diagnosis including essential hypertension, chronic kidney disease, and low back pain. On May 20, 2024, at 1:10 p.m. unlicensed personnel (ULP)-D was observed assisting R5 with a transfer from her chair to the hospital bed. R5's service plan dated March 20, 2023, indicated R5 needed assistance with activities of daily living (ADLs). R5's record indicated being admitted to the hospital on December 30, 2023, through January 3, 2024, after a fall resulting in an subarachnoid hemorrhage (bleeding in the brain). R5's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation.	01060			

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01060	Continued From page 16 - the name and contact information for the location to which the resident had been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care (OOLTC). - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On May 21, 2024, at 11:26 a.m. registered nurse (RN)-E stated she was aware of the emergency relocation process and showed the surveyor the form they used to send to the ombudsman if a hospital stay goes beyond three days. RN-E reviewed R5's electronic file, and the file did not contain the required document for the December 30, 2023, hospital stay and stated "it may just not be filed in the record" and "will look for it." The licensee's Emergency Relocation Policy dated June 2021, indicated that in the event of an emergency relocation, the licensee will provide a written notice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290			

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01290	Continued From page 17 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure they received a background study (BGS) clearance from NETStudy 2.0 (web-based system use to submit BGS requests to the Department of Human Services (DHS)) in affiliation with the assisted living with dementia care licensee's health facility identification number (HFID) 26730 for one of 70 employees (receptionist (R-G)). This has the potential to affect all residents residing within the facility and resulted in an immediate correction order on May 21, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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).	01290			

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01290	Continued From page 18 The findings include: R-G was hired on April 15, 2024, to provide part time receptionist duties. On May 21, 2024, the surveyor reviewed the licensee's NETStudy 2.0 roster for HFID 26730 and compared it with the licensee's current staff roster. The NETStudy 2.0 roster indicated R-G's BGS was affiliated with the licensee on April 18, 2024, and was currently "In Process." On May 21, 2024, at 10:13 a.m., assistant executive director (AED)-H stated R-G's BGS in NETStudy 2.0 indicated it was still in process. AED-H stated R-G had been fingerprinted but for some reason NETStudy 2.0 was not allowing them to review any results. AED-H stated they would need to call DHS today to find out what was going on with R-G's BGS. AED-H stated R-G was currently working today (May 21, 2024) and should have R-G call DHS if they were unable to get answers themselves. On May 21, 2024, at 11:01 a.m., the survey supervisor captured screen shots from NETStudy 2.0 which indicated R-G required supervision while working for the licensee, HFID 26730. It indicated the affiliation was last verified on April 18, 2024. On May 21, 2024, at 11:18 a.m., the surveyor observed R-G working at the front desk at the entrance of the facility. R-G stated they had worked for the licensee for about a month. R-G stated they worked every other weekend and filled in shifts when needed. R-G stated they worked unsupervised, and their duties included interacting with residents, checking people in and out of the facility, taking and delivering messages	01290			

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01290	Continued From page 19 to staff and residents, and was involved with facility activities taking on the role of BINGO caller. R-G further stated they interacted with residents on a regular basis. On May 21, 2024, 12:45 p.m., licensed assisted living director (LALD)-A and AED-H stated R-G was working at the front desk today (May 21, 2024). The surveyor questioned if R-G was being supervised, both stated there were supervisors and other employees in the building with R-G, but R-G did not have someone with them at all times. The licensee's 4.02 Background Studies policy dated June 2021, indicated: 1. Using the MN OHS NETStudy online program, Cannon Rivers Senior Living will initiate a background study on all employees being considered for hire. 2. If hired prior to receiving the results of the background study, or the tentative background study results indicate more time is needed requiring supervision, new hires shall not be permitted to interact or provide services to tenants or clients of Cannon Rivers Senior Living except under the direct supervision (eyesight) of another qualified staff person. 3. Once an approved background study has been received, staff may act independently with residents, assuming all other requirements have been met. 4. Copies of completed background studies shall be kept in individual employee records. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy was lifted on May 22, 2024,	01290			

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01290	Continued From page 20	01290			
	based on supervisor review; however, the deficiency remains at a level 3/WS (I).				
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30-days of providing services for one of one employee (unlicensed personnel (ULP)-C).	01440			

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01440	Continued From page 21 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: ULP-C was hired on December 19, 2022, to provide direct cares to residents. ULP-C's employee record lacked evidence a RN supervision was conducted within 30 days of providing delegated services. On May 20-22, 2024, the surveyor observed ULP-C perform medication administration and training for a newly hired employee. On May 22, 2024, at 10:40 a.m., clinical nurse supervisor (CNS)-B stated they did not complete a RN 30-day supervision for ULP-C. CNS-B stated they wanted to be transparent with the survey team and did not have RN 30-day supervisions completed for any of their ULP. CNS-B stated they were unaware of the RN 30-day supervision requirement. On May 22, 2024, at 12:21 p.m., ULP-C stated the RN had observed them regularly but was unsure if a RN supervision was completed when they were first hired. The licensee's 6.17 Supervision of Staff - Delegated Services policy, undated, and indicated a date of "XX/XX/XXXX", was a policy template which had not been customized to	01440			

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01440	Continued From page 22 include the licensee's name. In multiple places of the policy it had brackets where the licensee should have inserted their own licensee name, "[Name of AL]". It indicated: "POLICY: Staff who provide delegated nursing or therapy tasks to residents at [Name of AL] will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability perform the tasks. Supervision will include observation of the staff administering the medication or treatment and the interaction with resident. PROCEDURE: 1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [Name of AL] and first performs the delegated tasks for residents and thereafter as needed based on performance. 2. This requirement also applies to staff that have not performed delegated tasks for one (1) year or longer. 3. The supervision should be through the direct and indirect observation of the unlicensed personnel performing the services. The resident or resident's responsible person may be interviewed to assure they are satisfied with the services they are receiving. 4. It is the responsibility of the RN staff to ensure the supervision is done within the time frames outlined above and specified on the client's service plan. 5. Documentation of supervision activities will be retained in the employee's record." No further information was provided.	01440			

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01440	Continued From page 23	01440			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
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 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 a registered nurse (RN) conducted ongoing assessments not to exceed 90 calendar days from the last date of assessment for one of five residents (R3).	01620			

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01620	Continued From page 24 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on November 1, 2022. R3's ALF Service Plan dated June 5, 2023, indicated R3 received services for activities of daily living (ADLs) and medication management services. R3's record included three ALF Service Plan (which were also assessment) completed on June 6, 2023, September 21, 2023, and March 20, 2024. The September 21, 2023, assessment was completed 17 days past the 90 day requirement. The March 20, 2024, was completed 169 days past the 90 day requirement. On May 20, 2024, at 10:50 a.m. during the entrance conference, clinical nurse supervisor (CNS)-B stated they completed ongoing assessments quarterly and with a change of condition (COC). On May 22, 2024, at 3:23 p.m., CNS-B stated they completed ongoing assessments along with RN-E. CNS-B stated R3's assessments must have been missed somehow. CNS-B stated they lost their memory care nurse and since then, it had been difficult to keep up on resident	01620			

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01620	Continued From page 25 assessments. The licensee's 6.01 Assessment, Reviews & Monitoring policy, undated, indicated, "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." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to	01700			

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01700	Continued From page 26 manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a medication management assessment was completed by the registered nurse (RN) to determine what medication management services would be provided and included identification and review in all required areas for three of five residents (R2, R3, R4). 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 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: R2 R2 was admitted to the licensee on November 1, 2022, with diagnoses including dementia and type two diabetes. R2's ALF Service Plan dated November 9, 2023, indicated R2 received medication management services. R2's May 2024, medication administration record (MAR) indicated R2 took the following	01700			

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01700	Continued From page 27 medications: -acetaminophen 500 mg tablet, give two tablets by mouth (PO) three times per day for pain; -carvedilol tablet 12.5 mg, give one tablet PO two times a day for hypertensive heart disease with heart failure; -furosemide tablet 20 mg, give one tablet PO two times daily for hypertensive heart disease with heart failure; -glucose oral gel 15 g/32 ml, give one vial PO as needed (PRN) for blood glucose (BG) less than 70; -glucose oral tablet chewable 4 grams (g), give one tablet PO for BG less than 50 for type two diabetes; -Humalog KwikPen subcutaneous (SQ) solution pen-injector 100 units/milliliter (u/ml), inject 6 u SQ two times per day with noon and evening meals; -ipratropium-albuterol 0.5-2.5 3 mg/ 3 ml, inhale one vial PO PRN for shortness of breath four times per day; -loperamide hydrochloride (HCL) 2 mg capsule, give one capsule PO PRN for diarrhea and an additional capsule after each subsequent loose stool; -Lantus solution 100 u/ml, inject 18 u SQ at bedtime for type two diabetes; -Nystatin Powder, apply to abdominal folds topically two times a day for red skin; -ondansetron HCL oral tablet 4 mg, give one tablet every 12 hours PRN for nausea. -questran packet 4 g, give one packet PO one time a day for overactive stoma; and -sodium bicarbonate tablet 650 mg, give one tablet PO one time per day for supplement. R2's record lacked signed medication orders for the above listed medications with the exception of Nystatin powder, which was signed on June 20,	01700			

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01700	Continued From page 28 2023. R3 R3 was admitted to the licensee on November 1, 2022, with diagnoses including dementia. R3's ALF Service Plan dated June 5, 2023, indicated R3 received medication management services. R3's May 2024, MAR indicated R3 took the following medications: -aspirin 81 mg delayed release, one tablet PO every day; -calcium 600 with vitamin D3 chewable tablet, chew and swallow one tablet PO every day with breakfast; -cetirizine HCL 10 mg tablet, give one tablet PO one time a day for allergies: and -diclofenac sodium 1% gel, apply 4 g topically four times a day PRN for pain; -empagliflozin 25 mg tablet, take one tablet PO every morning with breakfast; -furosemide 20 mg tablet, take one tablet PO PRN; -glipizide 5 mg 24-hour XL (extended release) tablet, take one tablet PO daily; and -lisinopril 30 mg tablet, take one tablet PO every day; -meclizine 25 mg tablet, take one tablet PO three times a day PRN for dizziness; -melatonin 3 mg tablet, take one tablet PO at bedtime; -metformin XR (extended release) 500 mg 24-hour tablet, take one tablet PO twice daily with meals; -mirtazapine 15 mg tablet, take one tablet PO at bedtime; -oxymetazoline 0.05% nasal spray, administer two sprays into each nostril two times a day PRN;	01700			

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01700	Continued From page 29 -pediatric multivitamin-iron 18 mg chewable tablet, chew two tablets daily; -polyethylene glycol 17 g powder packet, take one packet PO PRN for constipation; -potassium chloride 20 milliequivalents (mEq) do not crush, take one tablet by mouth daily; -quetiapine 25 mg tablet, take 25 mg at bedtime for agitation and anxiety; -senna 8.6 mg tablet, take one tablet PO at bedtime; -simvastatin 20 mg tablet, take one tablet PO at bedtime. -crush all medications due to resident pocketing medications for every day and evening shift. R3's record lacked a provider order for cetirizine and to crush all medications. R4 R4 was admitted to the licensee on November 1, 2022, with diagnoses including dementia and diabetes. R4's ALF Service Plan dated April 26, 2024, indicated R4 received medication management services. R4's May 2024, MAR indicated R4 took the following medications: -amlodipine oral tablet 5 mg, give 5 mg PO one time daily for hypertensive chronic kidney disease; -aspirin 81 mg oral chewable tablet, give 81 mg PO one time daily for heart health; -Celexa oral tablet 20 mg, give 20 mg PO in the morning for depression; -cholecalciferol capsule 50 micrograms (mcg) 2000 u, give one capsule PO one time daily; -Depakote oral tablet delayed release 500 mg, give one tablet PO two times daily for depression;	01700			

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01700	Continued From page 30 -diphenhydramine HCL external cream 2%, apply to affected areas topically three times a day for itching; the MAR indicated the order was discontinued on May 1, 2024; -Eucerin cream, apply liberally to body at night; the MAR indicated the order was discontinued on May 1, 2024; -famotidine tablet 40 mg, give one tablet PO at bedtime; -fluticasone propionate nasal suspension 50 mcg, one spray in both nostrils PRN for allergies, 1 spray; -furosemide 20 mg tablet, take half a tablet (10 mg) PO in the morning for edema; -gabapentin oral capsule 300 mg, give 300 mg PO every eight hours PRN for agitation for 30 days; -glucose oral gel 15g/32 ml, give 15 g PO every 15 minutes PRN for low blood sugar, call RN for BG under 80; -glucose tablet chewable 4 g, give three tablets PO every 15 minutes PRN for low blood sugar; -Humalog KwikPen SQ solution pen-injector, inject 6 u SQ in the morning for diabetes; -Humalog KwikPen SQ solution pen-injector, inject 8 u SQ with lunch and supper for diabetes; -Humalog KwikPen SQ solution pen-injector, inject 2 u SQ with meals for BG over 350 for diabetes; -hydroxyzine HCL oral tablet 25 mg, give 25 mg PO every six hours PRN for anxiety; -hydroxyzine pamoate, give 25 mg PO every six hours PRN for itching; -Lantus SoloStar Solution Pen-Injector 100 u/ml, inject 18 u SQ at bedtime for type one diabetes; -Losartan potassium tablet 100 mg, give one tablet PO one time a day for hypertension; -Nitrostat tablet SQ 0.4 mg, give one tablet SQ every five minutes PRN for chest pain; -Sarna (camphor and menthol) lotion 0.5-0.5%,	01700			

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01700	Continued From page 31 apply to arms, back and chest topically for itching; and -senna tablet 8.6 mg, give one tablet PO two times daily PRN for constipation. R2, R3, and R4's record lacked evidence the RN conducted a face-to-face assessment with the resident and/or their representative to include a review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions and actions to address these issues. On May 21, 2024, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R3's medications. ULP-C was about to crush R3's medications when the surveyor stopped them. The surveyor questioned if there was an order for the medications to be crushed, ULP-C stated there was an order to crush all meds and showed it to the surveyor on the computer. The surveyor observed the medication bubble packs for some of the medications which indicated to swallow the tablets whole and do not break, chew or crush the medications. ULP-C stated they did not know what XL, ER or EX stood for on the bubble packs and did not notice the instructions on the medication bubble packs. She contacted the nurse. The following medications were about to be crushed: -aspirin 81 milligrams (mg) delayed release, one tablet by mouth (PO) every day; -glipizide 5 mg 24-hour XL (extended release) tablet, take one tablet PO daily; and -metformin XR (extended release) 500 mg 24-hour tablet, take one tablet PO twice daily with meals; and -potassium chloride 20 milliequivalents (mEq) do not crush, take one tablet by mouth daily.	01700			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
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01700	Continued From page 32 On May 21, 2024, at 7:34 a.m., ULP-C showed R3's medication bubble packs with the instruction to swallow the tablets whole and do not break, chew or crush the medications to clinical nursing supervisor (CNS)-B. CNS-B stated, "oh I didn't see that, good catch." CNS-B stated they should not be crushing extended-release medication. The surveyor inquired if they had an order to crush R3's medications, CNS-B stated they would look into it and contact the ordering provider. CNS-B stated they had not clarified if the extended-release medications should be crushed with the pharmacist or ordering provider. On May 22, 2024, at 3:23 p.m., CNS-B stated they had not completed and document a face-to-face medication management assessment for R2, R3, and R4 to include a medication reconciliation prior to administering orders to include side effects, crushed medications side effects and contraindications. The licensee's 7.03 Medication Management Individualized Plan policy, undated, indicated: "1. [Licensee name] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis	01700			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
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01700	Continued From page 33 e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications;	01730			

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01730	Continued From page 34 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to identify how a resident's medications would be stored, who would monitor medication supplies, and who would reorder medication for six of six residents (R2, R3, R4, R5, R6, R7). Further, the licensee failed to follow the resident's individualized medication management plan to ensure resident's prescribed medications and orders were current and accounted for after a provider appointment for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730			

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01730	Continued From page 35 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: R2 R2 was admitted to the licensee on November 1, 2022, with diagnoses including dementia. R2's ALF Service Plan dated November 9, 2023, indicated R2 received medication management services. R2's May 2024, electronic medication administration record (EMAR) included the following medications: -acetaminophen 500 mg for pain; -carvedilol 12.5 mg for hypertensive heart disease with heart failure; -furosemide 20 mg for hypertensive heart disease with heart failure; -Lantus solution 100 unit (u)/ milliliter (ml) for diabetes; -Humalog KwikPen for diabetes; -questran packet 4 grams (g), for overactive stoma; and -sodium bicarbonate 650 mg for supplement. R2's ALF Service Plan dated April 17, 2024, included R2's most recent medication management plan which lacked the following required information: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
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01730	Continued From page 36 -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements related to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medications use to prevent possible complications or adverse reactions; and -medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. R3 R3 was admitted to the licensee on November 1, 2022, with diagnoses including dementia. R3's ALF Service Plan dated June 5, 2023, indicated R3 received medication management services. R3's May 2024, EMAR included the following medications: -aspirin 81 mg used for heart health -calcium 600 with vitamin D3 for supplement; -cetirizine HCL 10 mg for allergies -empagliflozin 25 mg for diabetes -glipizide 5 mg for diabetes -lisinopril 30 mg for blood pressure -melatonin 3 mg for sleep; -metformin 500 mg for diabetes; -mirtazapine 15 mg for depression -pediatric multivitamin-iron 18 mg for supplement -potassium chloride 20 milliequivalents (mEq) for supplement	01730			

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01730	Continued From page 37 -quetiapine 25 mg for agitation and anxiety; -senna 8.6 mg for bowel management; and -simvastatin 20 mg for cholesterol. R3's ALF Service Plan dated March 20, 2024, included R3's most recent medication management plan which lacked the following required information: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements related to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medications use to prevent possible complications or adverse reactions; and -medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. R4 R4 was admitted to the licensee on November 1, 2022, with diagnoses including dementia. R4's May 2024, EMAR included the following medications: -amlodipine 5 mg for hypertensive chronic kidney disease; -aspirin 81 mg for heart health;	01730			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
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01730	Continued From page 38 -Celexa oral tablet 20 mg for depression; -cholecalciferol for supplement, -Depakote 500 mg for depression; -famotidine 40 mg for acid reflux; -furosemide 10 mg for edema; -Humalog KwikPen for diabetes; -Lantus SoloStar Solution Pen for diabetes; and -Losartan potassium tablet 100 mg for hypertension; R4's ALF Service Plan dated April 26, 2024, indicated R4 received medication management services. It included R4's most recent medication management plan which lacked the following required information: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements related to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medications use to prevent possible complications or adverse reactions; and -medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. R5	01730			

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01730	Continued From page 39 R5 was admitted to the licensee on November 1, 2022, with diagnoses of hypertension, chronic kidney disease and low back pain. On May 20, 2024, at 12:15 p.m. unlicensed personnel (ULP)-D was observed to administer noon medication to R5. R5's May 2024, electronic medical record (EMAR) included the following medications: - acetaminophen 500 mg for pain - chlorthalidone 25 mg used for high blood pressure. - levothyroxine 25 micrograms (mcg) used as a thyroid hormone. - loperamide 4 mg for loose stools. R5's Service Plan dated May 8, 2024, indicated R5 received medication management services. R5's service plan indicated R5 was unable to self-administer medication and that all medication will be administered by licensed or certified team members. It included R5's most recent medication management plan which lacked the following required information: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; R6 R6 was admitted to the licensee on November 1, 2022, with diagnoses of diabetes and hyperlipidemia R6's Service Plan dated April 9, 2024, indicated	01730			

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01730	Continued From page 40 R6 received medication management services. R6's service plan indicated R6 was unable to self-administer medication and that all medications will be administered by licensed or certified team members. It included R6's most recent medication management plan which lacked the following required information: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. R6's May 2024, EMAR included the following medications: - acetaminophen 500 mg for pain. - Zoloft 100 mg for depression - Novolog insulin 6 units for diabetes. - Lasix 40 mg for fluid retention. - Coumadin 5 mg for blood clotting. R7 R7 was admitted to the licensee on November 1, 2022, with diagnoses of anemia (low blood level), and coagulation defect (blood not clotting correctly). R7's Service Plan dated June 9, 2023, indicated R7 received medication management services and that medication will be administered by licensed or certified team members. It included R7's most recent medication management plan which lacked the following required information: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730			

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01730	Continued From page 41 -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; On May 20, 2024, at 12:15 p.m. ULP-D was observed administering noon medication to R7. R7's May 2024, EMAR included the following medications: - Aspirin 81 mg used for heart valve. - cetirizine tablet 10 mg used for allergies. - Coumadin table 2 mg used for controlling the thickness of blood. - Gabapentin 100 mg as needed for pain. On May 22, 2024, at 3:23 p.m., clinical nurse supervisor (CNS)-A stated they were pretty sure they did not have the missing medications management plan's required items as listed above. CNS-A stated it was the responsibility of the nurse performing the assessments and admission of residents. CNS-A stated they would continue to look for the missing information but said it was likely missing for all resident records. The licensee's 7.03 Medication Management Individualized Plan policy, undated, indicated: "1. [Licensee name] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of	01730			

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01730	Continued From page 42 medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and g. Any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions 2. The medication management record will be current and updated when there are any changes. 3. Medication reconciliation will be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by:	01820			

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01820	Continued From page 43 Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for three of five residents (R2, R3, R4). 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 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: R2 R2 was admitted to the licensee on November 1, 2022, with diagnoses including dementia and type two diabetes. R2's ALF Service Plan dated November 9, 2023, indicated R2 received medication management services. R2's May 2024, medication administration record (MAR) indicated R2 took the following medications: -acetaminophen 500 mg tablet, give two tablets by mouth (PO) three times per day for pain; -carvedilol tablet 12.5 mg, give one tablet PO two times a day for hypertensive heart disease with heart failure; -furosemide tablet 20 mg, give one tablet PO two times daily for hypertensive heart disease with heart failure; -glucose oral gel 15g/32ml, give one vial PO as needed (PRN) for blood glucose (BG) less than 70;	01820			

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01820	Continued From page 44 -glucose oral tablet chewable 4 grams (g), give one tablet PO for BG less than 50 for type two diabetes; -Humalog KwikPen SQ solution pen-injector 100 u/ml, inject 6 u SQ two times per day with noon and evening meals; -ipratropium-albuterol 0.5-2.5 3mg/3ml, inhale one vial PO PRN for shortness of breath four times per day; -loperamide hydrochloride (HCL) 2 mg capsule, give one capsule PO PRN for diarrhea and an additional capsule after each subsequent loose stool; -Lantus solution 100 unit (u)/ milliliter (ml), inject 18 u subcutaneously (SQ) at bedtime for type two diabetes; -ondansetron HCL oral tablet 4 mg, give one tablet every 12 hours PRN for nausea. -questran packet 4 g, give one packet PO one time a day for overactive stoma; and -sodium bicarbonate tablet 650 mg, give one tablet PO one time per day for supplement. R2's record lacked signed medication orders for the above listed medications. R3 R3 was admitted to the licensee on November 1, 2022, with diagnoses including dementia. R3's ALF Service Plan dated June 5, 2023, indicated R3 received medication management services. R3's May 2024, MAR indicated R3 took the following medication: -certirizine HCL 10 mg tablet, give one tablet PO one time a day for allergies: and -crush all medications due to resident pocketing medications for every day and evening shift.	01820			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009		
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01820	Continued From page 45 R3's record lacked a signed medication orders for certirizine HCL and medication instructions to crush all medications. R4 R4 was admitted to the licensee on November 1, 2022, with diagnoses including dementia and diabetes. R4's ALF Service Plan dated April 26, 2024, indicated R4 received medication management services. R4's May 2024, MAR indicated R4 took the following medications: -amlodipine oral tablet 5 mg, give 5 mg PO one time daily for hypertensive chronic kidney disease; -aspirin 81 mg oral chewable tablet, give 81 mg PO one time daily for heart health; -Celexa oral tablet 20 mg, give 20 mg PO in the morning for depression; -cholecalciferol capsule 50 micrograms (mcg) 2000 u, give one capsule PO one time daily; -Depakote oral tablet delayed release 500 mg, give one tablet PO two times daily for depression; -famotidine tablet 40 mg, give one tablet PO at bedtime; -fluticasone propionate nasal suspension 50 mcg, one spray in both nostrils PRN for allergies, 1 spray; -furosemide 20 mg tablet, take half a tablet (10 mg) PO in the morning for edema; -gabapentin oral capsule 300 mg, give 300 mg PO every eight hours PRN for agitation for 30 days; -glucose oral gel 15g/32ml, give 15 g PO every 15 minutes PRN for low blood sugar, call RN for BG under 80;	01820			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
(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
01820	Continued From page 46 -glucose tablet chewable 4 g, give three tablets PO every 15 minutes PRN for low blood sugar; -Humalog KwikPen SQ solution pen-injector, inject 6 u SQ in the morning for diabetes; -Humalog KwikPen SQ solution pen-injector, inject 8 u SQ with lunch and supper for diabetes; -Humalog KwikPen SQ solution pen-injector, inject 2 u SQ with meals for BG over 350 for diabetes; -hydroxyzine HCL oral tablet 25 mg, give 25 mg PO every six hours PRN for anxiety; -hydroxyzine pamoate, give 25 mg PO every six hours PRN for itching; -Lantus SoloStar Solution Pen-Injector 100 u/ml, inject 18 u SQ at bedtime for type one diabetes; -Losartan potassium tablet 100 mg, give one tablet PO one time a day for hypertension; -Nitrostat tablet SQ 0.4 mg, give one tablet SQ every five minutes PRN for chest pain; -Sarna (camphor and menthol) lotion 0.5-0.5%, apply to arms, back and chest topically for itching; and -senna tablet 8.6 mg, give one tablet PO two times daily PRN for constipation. R4's record lacked signed medication orders for the following medications: -amlodipine oral tablet 5 mg, give 5 mg PO one time daily for hypertensive chronic kidney disease; -cholecalciferol capsule 50 mcg 2000 u, give one capsule PO one time daily; -famotidine tablet 40 mg, give one tablet PO at bedtime; -fluticasone propionate nasal suspension 50 mcg, one spray in both nostrils PRN for allergies, 1 spray; -glucose oral gel 15g/32ml, give 15 g PO every 15 minutes PRN for low blood sugar, call RN for BG under 80;	01820			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
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01820	Continued From page 47 -glucose tablet chewable 4 g, give three tablets PO every 15 minutes PRN for low blood sugar; -Humalog KwikPen SQ solution pen-injector, inject 6 u SQ in the morning for diabetes; -Humalog KwikPen SQ solution pen-injector, inject 8 u SQ with lunch and supper for diabetes; -Humalog KwikPen SQ solution pen-injector, inject 2 u SQ with meals for BG over 350 for diabetes; -hydroxyzine HCL oral tablet 25 mg, give 25 mg PO every six hours PRN for anxiety; -hydroxyzine pamoate, give 25 mg PO every six hours PRN for itching; -Lantus SoloStar Solution Pen-Injector 100 u/ml, inject 18 u SQ at bedtime for type one diabetes; -Losartan potassium tablet 100 mg, give one tablet PO one time a day for hypertension; -Nitrostat tablet SQ 0.4 mg, give one tablet SQ every five minutes PRN for chest pain; -Sarna (camphor and menthol) lotion 0.5-0.5%, apply to arms, back and chest topically for itching; and -senna tablet 8.6 mg, give one tablet PO two times daily PRN for constipation. R4's May 2024, MAR indicated the following medications were discontinued: -diphenhydramine HCL external cream 2%, apply to affected areas topically three times a day for itching; and -Eucerin cream, apply liberally to body at night. R4's record lacked signed discontinued medication orders for diphenhydramine HCL and Eucerin cream. On May 22, 2024, at 3:23 p.m., the surveyor explained they could not find signed orders for the majority of R2 and R4's medications. Clinical nurse supervisor (CNS)-B stated they would look	01820			

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01820	Continued From page 48 into it and would provide orders. CNS-B stated it was their responsibility to make sure they had medication orders. CNS-B stated they had a nurse who worked on their memory care unit but were down to just two nurses after the memory care nurse left. Since then it had been difficult to keep up on resident records and orders. CNS-B stated they verified orders upon admission for residents so should have orders for R2 and R4. CNS-B stated they used an online portal to communicate with providers and will check it for additional medication order documentation. On May 23, 2024, at 10:19 a.m., CNS-B emailed signed orders for R2 and R4, both were dated May 23, 2024, which indicated they were signed during the survey process. The licensee's 7.20 Medication & Treatment Order policy, undated, indicated the RN is responsible for assuring, "current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records." Further, "A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter	01830			

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01830	Continued From page 49 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least annually, or every 12 months, for one of five residents (R4). 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: R4 R4 was admitted to the licensee on November 1, 2022. R4's diagnosis's included dementia and diabetes. R4's ALF Service Plan dated April 26, 2024, indicated R4 received medication management services. R4's May 2024, MAR indicated R4 took aspirin 81 mg oral chewable tablet, give 81 milligrams (mg) by mouth (PO) one time daily for heart health. R4's record included a Twin Cities Physicians prescription dated April 5, 2023, for aspirin 81 mg PO daily. R4's record lacked a renewed signed medication	01830			

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01830	Continued From page 50 order for aspirin 81 mg. On May 22, 2024, at 3:23 p.m., the surveyor explained they could not find renewal orders for some of R4's medications. Clinical nurse supervisor (CNS)-B stated they would look into it and provide orders. CNS-B stated it was their responsibility to make sure orders were renewed every 12 months. CNS-B stated they had a nurse who worked on their memory care unit but were now down to just 2 nurses after that nurse left which had made it difficult to keep up on resident records. CNS-B stated they used an online portal to communicate with providers and will check it for additional medication order documentation. On May 23, 2024, at 10:19 a.m., CNS-B emailed updated signed orders dated May 23, 2024 (during the survey process), for R4 which included aspirin 81 mg PO one time daily for heart health. The licensee's 7.20 Medication & Treatment Order policy, undated, indicated, "The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890			

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01890	Continued From page 51 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled with an opened date and/or prescription label for three of three residents (R2, R4, R8). 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: R2 R2 was admitted to the licensee on November 1, 2022, with diagnoses including dementia and type two diabetes. R2's ALF Service Plan dated November 9, 2023, indicated R2 received medication management services. R2's medication administration record (MAR) printed on May 22, 2024, indicated R2 was administered the following medication on May 1-21, 2024: -Lantus Solution (insulin glargine) 100 unit (u)/milliliter (ml), inject 18 u subcutaneously (SQ) at bedtime for type two diabetes.	01890			

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01890	Continued From page 52 R2's prescription form dated March 8, 2023, indicated R2 took the following medication: -Lantus 14 u, SQ at bedtime. R4 R4 was admitted to the licensee on November 1, 2022, with diagnoses including dementia and diabetes. R4's ALF Service Plan dated April 26, 2024, indicated R4 received medication management services. R4's MAR form printed on May 22, 2024, indicated R4 was administered the following medication on May 1-19, 2024: -Lantus SoloStar Solution Pen-Injector 100 u/ml, inject 18 u SQ at bedtime for type one diabetes. R8 R8 was admitted to the licensee on November 1, 2022, with diagnoses including Lewy Body dementia and type two diabetes. R8's ALF Service Plan dated September 26, 2023, indicated R8 received medication management services. R8's MAR form printed on May 23, 2024, indicated R8 was administered the following medication on May 1-22, 2024: -Insulin Glargine SoloStar Solution Pen-Injector 100 u/ml, inject 50 u SQ at bedtime. R8's medication orders, Medication Review Report dated July 17, 2023, indicated R8 took: -Insulin Glargine SoloStar Solution Pen-Injector 100 u/ml, inject 50 u SQ at bedtime.	01890			

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01890	Continued From page 53 On May 20, 2024, at 12:33 p.m., the surveyor observed the memory care medication cart located in the dining room with unlicensed personnel (ULP)-C. the surveyor observed a Lantus SoloStar (insulin glargine) injection pen in R4's medication compartment (the compartment was labeled with an incorrect room number for R4) which lacked resident identifying labels and an open date; 140 u of insulin remained in the pen out of 300 u, which indicated the insulin pen had been used. The surveyor observed a second Lantus SoloStar injection pen in R8's medication compartment which lacked resident identifying labels and an open date; 230 u of insulin remained in the pen out of 300 u, which indicated the insulin pen had been used. The surveyor observed a third Lantus SoloStar injection pen in R2's medication compartment which lacked an open date. ULP-C stated all three Lantus SoloStar injection pens were currently being used. ULP-C stated they try and help with medication cart audits but it was the primary responsibility of clinical nurse supervisor (CNS)-B to audit them weekly. ULP-C removed the three Lantus SoloStar injection pens from the medication cart and planned to call the nurse. On May 20, 2024, at 12:40 p.m., ULP-C returned to the suveyor with the three Lantus SoloStar injection pens and wanted to return them to the medication cart. ULP-C stated they checked the medication refrigerator and were able to determine the two unlabeled pens must have belonged to R4. The suveyor observed the two unlabeled insulin pens were still unlabeled with a resident identifying label or an open date. The surveyor observed R2's insulin pen was the same pen without an open date. ULP-C stated they had not contacted the nurse. The surveyor inquired what a ULP should do if they find medication	01890			

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01890	Continued From page 54 problems, ULP-C stated they should contact the nurse and would do so immediately. The surveyor observed ULP-C take the three insulin pens to the memory care office and call the nurse. On May 20, 2024, at 12:48 p.m., the surveyor observed the medication refrigerator with ULP-C in the memory care office which had a box with three remaining new Lantus Solostar injection pens. The box had a pharmacy label with R4's information; however, the three remaining insulin pens inside the box were unlabeled. On May 21, 2024, at 7:12 a.m., CNS-B stated they reviewed the medication cart one time per week but did not see the above issues at her last weekly check. CNS-B stated the unlabeled insulin pens should not have been in the medication cart and were discarded yesterday (May 20, 2024). CNS-B stated they contacted the pharmacy about the insulin pen labeling and they were going to send additional labels for staff to use going forward. CNS-B stated an unlabeled insulin pen should never be used and would be conducting education for the ULP. The manufacturer's instructions for Lantus SoloStar injection pens indicated, "Keep your SoloStar in cool storage (36°F-46°F [2°C-8°C]) until first use. Do not allow it to freeze. Do not put it next to the freezer compartment of your refrigerator or next to a freezer pack. Once you take your SoloStar out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar in use must not be stored in a refrigerator." The licensee's 7.11 Medication Storage policy,	01890			

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01890	Continued From page 55 undated and indicated a date of "XX/XX/XXXX", was a policy template which had not been customized to include the licensee's name. In multiple places of the policy it had brackets where the licensee should have inserted their own licensee name, "[Name of AL]". The policy indicated, "Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." The licensee's 7.13 Medication - Prescription Drugs & Prohibition policy, undated and indicated a date of "XX/XX/XXXX", was a policy template which had not been customized to include the licensee's name. In the first line of the policy it had brackets where the licensee should have inserted their own licensee name, "[Name of AL]". The policy indicated: "POLICY: When [Name of AL] receives a prescription drug, prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No prescription drug supply for one resident may be used or saved for use by anyone other than the resident." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures	02110			

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02110	Continued From page 56 required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures	02110			

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02110	Continued From page 57 for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for two of three dementia care residents (R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3 was admitted to the licensee on November 1, 2022. R4 was admitted to the licensee on November 1, 2022. R3 and R4's records lacked evidence the licensee provided the resident, or residents' designated representative, with the required policies and procedures for the ALFDC license. On May 22, 2024, at 2:42 p.m., licensed assisted living director (LALD)-A's email indicated, "We do not have signed documentation of the handout for [R4] and [R3]," in reference to the required dementia care policies. On May 22, 2024, at 2:55 a.m., LALD-A stated R2 had the required documentation for dementia care policies which were provided to R2 by the previous owner of the licensee. LALD-A stated R3 and R4's record lacked the required documentation for dementia care policies.	02110			

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NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
(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
02110	Continued From page 58 LALD-A stated they were currently not providing the required dementia care policy information to residents or designated representatives but were working on implementing it with their admission process. LALD-A questioned if they just needed a document with a signature or if they needed every policy to be signed. The surveyor explained the statute requirement. The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies policy dated June 2021, indicated, "Because Cannon Rivers Senior Living has an Assisted Living with Dementia Care license, in addition to the policies and procedures required for the facility written policies and procedures must address the following list." The policy listed the 10 dementia care policies required for an ALFDC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			
02310 SS=G	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 care and services were provided according to acceptable health care and medical or nursing standards for	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
(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 59 one of two residents (R5) with siderails. This resulted in an immediate correction order on May 21, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 began receiving services on November 1, 2022, with a diagnosis including essential hypertension, chronic kidney disease, and low back pain. R5's comprehensive assessment dated March 21, 2024, indicated R5 received hospice services and required assistance with medication administration, bathing, dressing, and transfers with the use of a hooyer lift. On May 20, 2024, at 12:15 p.m. unlicensed personnel (ULP)-D and ULP-F were observed transferring R5 into bed with the use of a hooyer lift. R5 was observed lying in a hospital bed with bilateral upper siderails in the upward position. On May 21, 2024, at 8:15 a.m. clinical nurse supervisor (CNS)-B stated she was unaware of when R5 received a hospital bed, but it was provided by hospice. They completed the assessment "last night" and were waiting for the measurements from the maintenance department.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
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02310	Continued From page 60 On May 21, 2024, at 8:30 a.m. registered nurse (RN)-E stated she completed R5's siderail assessment yesterday (after the start of the survey). RN-E stated measurements have not been completed yet and have contacted the maintenance department to complete today. RN-E further stated they have not completed education on the risks and benefits of bed rail use with R5 or their representative, and were inquiring with hospice to see if they had completed that step. On May 21, 2024, at 9:23 a.m. licensed assisted living director (LALD)-A stated they try to make sure siderails were identified, but this one was missed. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (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 licensee's Siderails policy dated June 2021, indicated when siderails are in use, a registered	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 26730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER CANNON FALLS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 900 MAIN STREET WEST CANNON FALLS, MN 55009			
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02310	Continued From page 61 nurse (RN) must conduct an assessment to identify the intended the intended purpose of the siderail and the risks regarding the use of the side rails. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy was lifted on May 22, 2024, by supervisor review; however, the deficiency remains at a level 3/Isolated (G).	02310			

Type: Full
Date: 05/22/24
Time: 09:58:41
Report: 8074241096

Food and Beverage Establishment
Inspection Report

Page 1

Location:

Cannon Rivers Senior Living
900 Main Street West
Cannon Falls, MN55009
Goodhue County, 25

Establishment Info:

ID #: 0037757
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072636062
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

MILK, EGG SALAD, POTATO SALAD ABOVE 41DF BUT BELOW 45DF, REPAIR UNIT, IF UNIT DOES NOT DROP BELOW 41DF IN HOUR DISCARD FOOD.

Comply By: 05/22/24

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Comply By: 05/22/24

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

Comply By: 05/22/24

Type: Full
Date: 05/22/24
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Report: 8074241096
Cannon Rivers Senior Living

Food and Beverage Establishment Inspection Report

Page 2

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.

COOLER IN MEMORY CARE UNIT 44DF

Comply By: 05/22/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

Cove base missing by grease trap of three compartment sink. Corner plastic by entry is cracked and broken.

Comply By: 07/31/24

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit

Location: internal dish machine

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking

Temperature: 165 Degrees Fahrenheit - Location: stuffed pepper

Violation Issued: No

Process/Item: Walk-In Cooler

Temperature: 40 Degrees Fahrenheit - Location: mac and cheese

Violation Issued: No

Process/Item: Walk-In Cooler

Temperature: 41 Degrees Fahrenheit - Location: noodles

Violation Issued: No

Process/Item: Cooking

Temperature: 122 Degrees Fahrenheit - Location: cream corn from can

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 43 Degrees Fahrenheit - Location: milk

Violation Issued: Yes

Process/Item: Cooling

Temperature: 51 Degrees Fahrenheit - Location: cut melon

Violation Issued: No

Process/Item: Upright Cooler

Temperature: 38 Degrees Fahrenheit - Location: juice

Violation Issued: No

Type: Full
Date: 05/22/24
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Food and Beverage Establishment Inspection Report

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Process/Item: Upright Cooler
Temperature: 44 Degrees Fahrenheit - Location: egg salad
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 44 Degrees Fahrenheit - Location: potato salad
Violation Issued: Yes

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

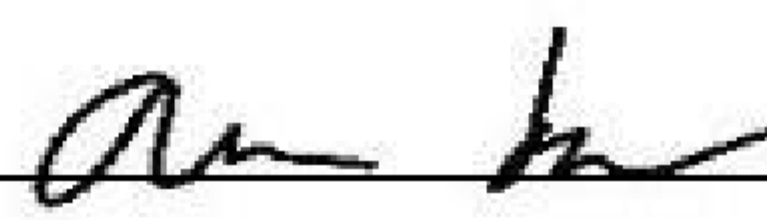
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8074241096 of 05/22/24.

Certified Food Protection Manager: Benjamin Hill

Certification Number: Fm84706 Expires: 06/15/25

Signed: _____
Establishment Representative

Signed: 
Andrea Kieffer

Rochester District Office