Electronically Delivered

January 22, 2024

Licensee
The Prairie Lodge At Earle Brown
6001 Earle Brown Drive
Brooklyn Center, MN 55430

RE: Project Number(s) SL20315015

Dear Licensee:

On November 16, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 28, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 28, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 28, 2023, found not corrected at the time of the November 16, 2023, follow-up survey and/or subject to penalty assessment are as follows

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 = $500.00

The details of the violations noted at the time of this follow-up survey completed on November 16, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process.

The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20315	A. BUILDING: _____ B. WING _____	R 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

(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: SL20315015-1 On November 14, 2023, through November 16, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on July 28, 2023. At the time of the survey, there were 42 residents: 41 of whom received services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 510}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for	{0 550}		

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{0 550}	Continued From page 2 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action required.	{0 550}		
{0 650} SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and	{0 650}		

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{0 650}	Continued From page 3 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: No further action required.	{0 650}		
{0 660} SS=E	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: No further action required.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	{0 680}		

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{0 680}	Continued From page 4 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}		
{0 800} SS=C	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:	{0 800}		

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{0 800}	Continued From page 5 Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. 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 potential to affect a large portion or all of the residents). The findings include: On November 16, 2023, from 10:30 a.m. to 12:30 p.m., survey staff toured the facility with the environmental services director (ESD)-F. The following was observed: Building 6011 The laundry room floor had signs of water damage. The floor material was raised and no longer adhered to the subfloor along the wall adjacent to one of the washing machines. Other pieces of the flooring in that area were stained and some had a white residue on them. ESD-F stated that the same flooring contractors who were working on the employee breakrooms in each building at the time of the survey would be replacing the laundry room floors during the same week, but no work had been started in the laundry rooms at the time of the survey.	{0 800}		

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{0 800}	Continued From page 6 Building 6001 The wall corners at the uncased opening behind the nurse's station were heavily damaged. Damage was more extensive than typical wear and tear. There were large areas where the drywall was broken and trim pieces had been bent by heavy impact. During interview on November 16, 2023, at 12:30 p.m., ESD-F stated they were working on repairing all the damaged corners and installing corner guards on each corner to avoid future damage in each of the buildings. At the time of the survey, it was observed that work had been done to repair some of the damaged corners in each building, but there were still a significant number of corners with damage that exposed the wall cavity and sharp building materials. TIME PERIOD FOR CORRECTION: Seven (7) days.	{0 800}		
{01060} SS=F	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. (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	{01060}		

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{01060}	Continued From page 7 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: No further action required.	{01060}		
{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section	{01290}		

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{01290}	Continued From page 8 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action required.	{01290}		
{01440} SS=D	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	{01440}		

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{01440}	Continued From page 9 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: No further action required.	{01440}		
{01620} SS=E	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:	{01620}		

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{01620}	Continued From page 10 No further action required.	{01620}		
{01640} SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action required.	{01640}		
{01650} SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	{01650}		

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{01650}	Continued From page 11 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: No further action required.	{01650}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of	{01760}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

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{01760}	Continued From page 12 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescribed follow-up of abnormal clinical monitoring results for four out of nine residents (R3, R12, R14, R18). Furthermore, the licensee failed to document administration or refusal of medications according to provider orders for one of nine residents (R18) and failed to ensure medications were administered per prescriber order or manufacturer recommendations for two of nine residents (R14, R25). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: LACK OF FOLLOW UP R3 R3 was admitted on June 19, 2017, with diagnoses of cerebral palsy, depression, hypertension, and lymphedema.	{01760}		

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{01760}	Continued From page 13 R3's Service Plan signed on October 3, 2023, indicated R3 received medication management and medication administration five times daily. R3's Physician Order Sheet signed on August 21, 2023, indicated R3 received carvedilol 25 milligrams (mg), two tablets twice daily for hypertension. In addition, the physician ordered blood pressure to be checked before administration and the nurse to be notified if the top number of the blood pressure reading was below 100 or above 180 and if the bottom number was below 50 or above 100. On November 14, 2023, during continuous observation from 3:00 p.m. to 3:35 p.m., the surveyor observed unlicensed personnel (ULP)-T prepare medications for R3 and enter R3's room. ULP-T had all R3's medications in one medication cup including two tablets of 25 mg carvedilol. ULP-T checked R3's blood pressure with an electronic upper arm monitor. R3's blood pressure was 145/109. ULP-T handed the prepared medication cup to R3. R3 put all the medications in her mouth and swallowed them with a drink of water. ULP-T left R3's room and went back to the medication cart in the hallway by R3's room. The surveyor asked ULP-T about the blood pressure reading and if there was any follow-up needed. ULP-T stated the blood pressure reading was fine and signed off administering the medications on the Medication Administration Record (MAR). The surveyor specifically asked ULP-T if the bottom number of the blood pressure met the parameter of being below 100. ULP-T stated, "oh, no, I should have notified the nurse". ULP-T walked to the nursing office and notified registered nurse (RN)-S in person of the blood pressure reading and administration of carvedilol. RN-S stated since	{01760}		

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{01760}	Continued From page 14 the blood pressure reading was high, they would have directed ULP-T to go ahead and administer the carvedilol. RN-S would notify the physician of the elevated reading. On the October 2023 MAR, ULPs documented R3's blood pressure readings taken with her morning dose of carvedilol to have the bottom number above 100 fourteen out of thirty-one times. These readings outside of the parameters ordered by R3's physician occurred on October 1, 2, 7, 9, 11, 19, 21, 24, 25, 26, 28, 30, and 31, 2023. Blood pressure readings were documented for all morning shifts in October. Carvedilol was documented to have been administered on all mornings in October. On the October 2023 MAR, ULPs documented R3's blood pressure readings taken with R3's 3:30 p.m. dose of carvedilol to have the bottom number above 100 seven out of twenty-nine times. These readings outside of the parameters order by R3's physician occurred on October 2, 3, 6, 9, 21, 25, and 27, 2023. There were two times, occurring on October 7 and 15, 2023, with no blood pressure reading documented. On October 7 the carvedilol was documented to be administered. On October 15 there is no documentation for administration. The documentation notes at the end of the October 2023 MAR did not contain any entries related to carvedilol for reason given, held, or reported to the nurse. On the November 2023 MAR, dated November 1 to November 14, 2023, ULPs documented R3's blood pressure readings taken with her morning dose of carvedilol to have the bottom number above 100 six out of fourteen times. These	{01760}		

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{01760}	Continued From page 15 readings outside of the parameters ordered by R3's physician occurred on November 2, 4, 9, 10, 12, and 13, 2023. Blood pressure readings were documented for all morning shifts in November. Carvedilol was documented to be administered on all mornings in November. On the November 2023 MAR, dated November 1 to November 14, 2023, ULPs documented R3's blood pressure readings taken with R3's 3:30 p.m. dose of carvedilol to have the bottom number above 100 five out of fourteen times. These readings outside of the parameters order by R3's physician occurred on November 4, 6, 8, 9, and 14, 2023. Blood pressure readings were documented for all 3:30 p.m. shifts in November. Carvedilol was documented to be administered on all 3:30 p.m. shifts in through November 14. The documentation notes at the end of the November 2023 MAR did not contain any entries related to carvedilol for reason given, held, or reported to the nurse. R3's Progress Notes for from October 1, 2023, to November 15, 2023, indicated nursing was aware of the elevated blood pressure readings on October 2 and updated the physician, and on November 14, 2023, RN-S documented the elevated blood pressure recording from ULP-T and notification to the physician by RN-S. There were no progress notes between October 2, 2023, and November 14, 2023, about elevated blood pressure readings, administration of carvedilol, or notification to the physician. R12 R12 was admitted on November 12, 2019, with diagnoses of Type II Diabetes with diabetic polyneuropathy, major depressive disorder,	{01760}		

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{01760}	Continued From page 16 chronic obstructive pulmonary disease (COPD), and Stage III Chronic Kidney Disease. R12's service plan, signed on October 30, 2023, indicated R12 received medication management, treatment management, medication administration, and blood pressure checks three times weekly. R12's Physician Orders, dated August 17, 2023, indicated blood pressure to be checked three times per week and the registered nurse to be notified if the top number was below 70 or above 180 and if the bottom number was below 50 or above 100. On R12's MAR, dated November 1 to November 16, 2023, ULPs documented R12's blood pressure readings to have the bottom number above 100 on November 1, 3, and 6, 2023. R12's MAR dated November 1 through 16, 2023, lacked any notes from ULPs about notifying nursing regarding the elevated blood pressure readings. R12's Progress Notes, from November 1 through November 16 did not contain any documentation of notification to nursing or updates to the physician of elevated blood pressure readings. LACK OF FOLLOW-UP AND DOCUMENTATION ERROR R14 R14 was admitted on June 10, 2015, with diagnoses of Diabetes Type II, schizophrenia, chronic obstructive pulmonary disease (COPD), hypertension, hypothyroidism, depression, glaucoma, and chronic diastolic heart failure.	{01760}		

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{01760}	Continued From page 17 R14's service plan, signed on November 7, 2023, indicated R14 received medication management, treatment management, medication administration, and blood glucose monitoring four times daily. R14's Physician Orders, dated August 25, 2023, indicated R14 received COQ10 enzyme one capsule daily by mouth at 11:30 a.m. and blood glucose to be checked four times daily at 7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m., and to notify the nurse if blood glucose level was above 400 or below 70. On November 15, 2023, at 11:30 a.m., the surveyor observed ULP-M prepare medications for R14. When ULP-M attempted to prepare the scheduled COQ10 enzyme softgel or gummie, the gummie bottle R14 had been using was in the cart but empty. ULP-M looked through the cart and medication room for a new bottle but was unable to locate one. ULP-M took the other 11:30 a.m., medications into R14's room and told him about the empty COQ10 enzyme bottle. R14 stated they knew the ULP gave him the last gummie yesterday and they were going to switch to softgels but had not received them from the pharmacy yet. On November 16, 2023, at 1:00 p.m., while reviewing documentation the surveyor observed R14's MAR for November 1 through 16, 2023, ULP-M had initialed the entry for COQ10 enzyme gummies on November 15, 2023, 11:30 a.m., indicating the dose had been administered. There was not a note at the end of the MAR for November 15 about running out of COQ10 enzyme. R14's MAR, dated October 1 through 31, 2023,	{01760}		

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{01760}	Continued From page 18 indicated R14's blood glucose level was above 400 when checked at 11:30 a.m. on October 2 and 9. When checked at 4:30 p.m., R14's blood glucose level was above 400 on October 8, 10, 18, 19, and no result noted on October 30. At 8:00 p.m., R14's blood glucose level was above 400 on October 6, 9, 15, 16, and 18. R14's MAR, dated November 1 through 15, 2023, indicated R14's blood glucose level was above 400 when checked at 11:30 a.m. on November 1, 3, 5, 7, and 9. At 7:50 p.m., R14's blood glucose level was above 400 on November 6, 7, and 9. R14's MAR dated October 1 through 31, 2023, and November 1 through 15, lacked any notes from ULPs about notifying nursing about the elevated blood glucose levels on the referenced dates. R14's Progress Notes, from October 1 through November 15 did not contain any documentation of notification of elevated blood glucose levels. LACK OF FOLLOW-UP AND REFUSED MEDICATION NOT DOCUMENTED R18 R18 was admitted on October 1, 2021, with diagnoses of diabetes mellitus, chronic obstructive pulmonary disease (COPD), schizophreniform disorder, and chronic pain. R18's Service Plan signed on October 2, 2023, indicated R18 received medication management and medication administration including oral medications five times daily, inhaler four times daily, topical three times daily, insulin administration one time daily, and a monthly injection. In addition, R18 received oxygen safety checks that included checking R18's oxygen	{01760}		

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{01760}	Continued From page 19 saturation or ensuring R18 was wearing their oxygen six times daily. R18's Physician Order Sheet signed on August 18, 2023, indicated R18 had oxygen one to two liters daily and directed staff to make sure R18 was wearing her oxygen at bedtime/ night. In addition, there was an as needed order for oxygen one to two liters for when oxygen level was low and/or R18 was short of breath. On November 14, 2023, at 3:55 p.m., the surveyor observed ULP-T check R18's oxygen (O2) saturation (sats) level with a result of 89 percent (%). ULP-T offered R18 oxygen but R18 refused stating they were going outside to smoke a cigarette. ULP-T stated R18 can have one to two liters of O2 when R18's O2 sats were less than 90%. The surveyor asked ULP-T how they determine if R18 should have one liter or two liters. ULP-T stated they put on one liter if R18's O2 sats were low but not too low, and they would put on two liters of O2 if R18's O2 sats were "low low". R18's Service Checkoff List, dated October 1 through 31, 2023, indicated R18's O2 sats were below 90% when checked at 7:45 a.m. on October 2, 19 and 26. At 7:45 a.m., on the following dates the entries were initialed by ULPs but no O2 sat was entered, October 1, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 20, 21, 22, 23, 28 and 29. R18's Service Checkoff List, dated October 1 through 31, 2023, indicated R18's O2 sats were below 90% when checked at 12:45 p.m. on October 2, 19, 26, and 30. At 12:45 p.m., on the following dates the entries were initialed by ULPs but did not have a number for the O2 sat entered,	{01760}		

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{01760}	Continued From page 20 October 1, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 20, 21, 22, 23, 28 and 29. R18's Service Checkoff List, dated October 1 through 31, 2023, indicated R18's O2 sats were below 90% when checked at 4:00 p.m. on October 15 and 18. At 4:00 p.m., on the following dates the entries were initialed by ULPs but did not have a number for the O2 sat entered, October 3, 8, 16, and 28. R18's MAR dated October 1 through 31, 2023, indicated no as needed oxygen had been used or refused during the month on any shift. R18's Service Checkoff List, dated November 1 through 16, 2023, indicated R18's O2 sats were below 90% when checked at 7:45 a.m. on November 2 and 16. At 7:45 a.m., on the following dates the entries were initialed by ULPs but no O2 sat was entered, November 1, 4, 9, 11, and 12. R18's Service Checkoff List, dated November 1 through 16, 2023, indicated R18's O2 sats were below 90% when checked at 12:45 p.m. on November 2. At 12:45 p.m., on the following dates the entries were initialed by ULPs but did not have a number for the O2 sat entered, November 1, 4, 6, 9, 11, and 12. R18's Service Checkoff List, dated November 1 through 16, 2023, indicated R18's O2 sats were below 90% when checked at 4:00 p.m. on November 8, 10, and 14. At 4:00 p.m., on the following dates the entries were initialed by ULPs but did not have a number for the O2 sat entered, November 1, 2, 5, 11, and 13. R18's MAR dated November 1 through 16, 2023,	{01760}		

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{01760}	Continued From page 21 indicated no as needed oxygen had been used or refused during the referenced timeframe. R18's Progress Notes, requested for October and November, had notes on November 6 and 9 and no notes related to oxygen use, oxygen refusal, or notification of O2 sats out of the range identified to notify the nurse on the Physician Orders. On Wednesday, November 15, 2023, at 1:30 p.m., RN-S stated they would expect ULPs to document R18's refusal to apply oxygen when saturation levels are below 90% as a refused medication on the MAR. RN-S also stated they would expect to see notification of an abnormal result from the ULP to nursing in the notes on the MAR, and updates to the physician from the nurse in the resident's progress notes. MANUFACTURER'S GUIDELINES R25 R25 was admitted on October 20, 2020, with diagnoses of unspecified cirrhosis of the liver, adjustment disorder with mixed anxiety and depressed mood, chronic obstructive pulmonary disease (COPD), limitation of activities due to disability, major depressive disorder, and chronic pain. R25's Service Plan signed on November 15, 2023, indicated R25 received medication management and medication administration. R25's Physician Order Sheet signed on August 17, 2023, indicated R25 received buprenorphine hydrochloride (hcl)/ naloxone hcl (Suboxone) 2 mg- 0.5 mg sublingual film every day with instructions to place 1.5 film under the tongue two times daily in the AM and at 4:00 p.m., as	{01760}		

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{01760}	Continued From page 22 indicated for chronic pain syndrome. On November 14, 2023, at 4:04 p.m., the surveyor observed ULP-T preparing medications for R25. ULP-T removed two film packages of Suboxone from the controlled substances drawer, removed one of the films from the package, cut the film in half, put half of the film back into the foil package, returned the open package to the supply drawer, documented how many films were left and included one-half in her note. ULP-T brought the Suboxone films and R25's other scheduled medications into R25's room and R25 took the film and one-half film of Suboxone and placed them under her tongue as directed for medication delivery. On November 15, 2023, at 1:30 p.m., RN-S reviewed the Suboxone order and stated he would cut the film in half based on the order. RN-S called Thrifty White Pharmacy and stated the Pharmacist stated to them that it is not ideal to cut the film in half. The Food and Drug Administration's (FDA) resource document Highlights of Prescribing Information for Suboxone, dated as revised in March 2021, indicated the entire Suboxone sublingual film should be administered at once and not to cut, tear, chew, or swallow Suboxone sublingual film. The licensee's policy Documentation of Medication, Treatment and Therapy Management Services, dated August 1, 2021, indicated the RN would provide specific instructions for administering PRN medications, treatment, and therapy consistent with the prescriber's prescription for the reason under which the PRN's may be administered. The RN would also provide	{01760}		

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{01760}	Continued From page 23 detailed instructions on the use of a PRN medication, treatment, or therapy as per the prescriber's order, and would include the need and interval to monitor and report effectiveness to the RN. The licensee's policy Training Unlicensed Personnel for Medication, Treatment, and Therapy Administration, dated August 1, 2021, indicated ULPs are trained and deemed competent in learning the type of information reportable to a nurse regarding assistance or administration of medications, treatment and therapy including side effects, effectiveness, refused or held medications and medication errors and provision of treatment and therapy.	{01760}		
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the	{01790}		

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{01790}	Continued From page 24 unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	{01790}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20315	A. BUILDING: _____ B. WING _____	R 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

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{01790}	Continued From page 25 This MN Requirement is not met as evidenced by: No further action required.	{01790}		
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: No further action required.	{01880}		
{01890} SS=D	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 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 maintained to include the opened-on date for time sensitive medication storage for two of eight residents (R18, R20). 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	{01890}		

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{01890}	Continued From page 26 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: R18 R18 admitted to licensee on October 1, 2021, and had diagnoses including chronic obstructive pulmonary disease (COPD), type II diabetes mellitus, inflammatory spondylopathy of the lumbar region, schizophreniform disorder, and chronic pain. R18's Service Plan signed on October 2, 2023, indicated R18 received medication management and medication administration including oral medications five times daily, inhaler four times daily, topical three times daily, insulin administration one time daily, and a monthly injection. R18's prescriber orders dated August 15, 2023, ordered: - Combivent Respimat inhaler, inhale one puff four times per day for COPD. On November 14, 2023, at 3:55 p.m., the surveyor observed unlicensed personnel (ULP)-T administer Combivent Respimat inhaler one puff by mouth. The Combivent Respimat inhaler did not have an opened-on date noted on the inhaler or the box it came in. R20 R20 was admitted to licensee on June 30, 2018, and had diagnoses including diabetes mellitus, hypertension, mitral stenosis, and schizophrenia.	{01890}		

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{01890}	Continued From page 27 R20's AL Nursing Assessment dated June 20, 2023, assessed R20 required assistance with medication administration. R20's prescriber orders dated October 19, 2023, ordered: -insulin Humalog subcutaneous (SQ) injection - 22 units with breakfast in the morning; - 22 units with lunch at noon; and - 25 units with dinner in the evening. On November 14, 2023, at 4:20 p.m., the surveyor observed ULP-T administer R20's scheduled oral medications and check R20's blood glucose level. ULP-T stated they planned to administer R20's insulin closer to dinner time. ULP-T did take the lispro KwikPen out of the medication cart to demonstrate how ULP-T was trained. The surveyor observed the lispro KwikPen was open in the medication cart but did not have an opened-on date noted on the KwikPen. ULP-T stated the lispro KwikPen should have a yellow sticker with the opened-on date, or the date should be written on the pen in black permanent marker. ULP-T put the unlabeled lispro KwikPen back into the medication cart and left the area. The surveyor returned to the survey room, which was across the hall from R20's apartment. On November 14, 2023, at 5:00 p.m., the surveyor observed ULP-T administer 25 units of lispro insulin with the undated lispro KwikPen into R20's left upper arm. ULP-T stated they had asked registered nurse (RN)-S about it and RN-S instructed them to go ahead and use the pen. On November 15, 2023, at 12:02 p.m., the surveyor observed ULP-U administer 22 units of lispro insulin with the lispro KwikPen into R20's	{01890}		

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{01890}	Continued From page 28 left upper arm. This was the same KwikPen that had been in the medication cart but now dated November 14, 2023, with permanent marker. On November 15, 2023, at 1:30 p.m., RN-S stated ULP-T did ask them about the lispro KwikPen on November 14. At that time RN-S stated they looked up when the KwikPen was delivered and directed ULP-T to put that date on the pen as it was the earliest possible date the pen could have been opened and put into the medication cart. The delivery date was November 2, 2023, and RN-S determined the lispro KwikPen was still safe to use. RN-S stated they would change the date on the KwikPen to November 2, 2023. RN-S stated their expectation was that ULPs put the date on medications when they open a new medication. RN-S stated there are bright yellow stickers in the carts for them to label the insulin pens with and black permanent markers for labeling everything else. Lispro KwikPen manufacturer instructions dated as revised September 21, 2023, directed when stored at room temperature, lispro could be used for a total of twenty-eight days. Lispro Kwikpens should be discarded twenty-eight days after opened. Combivent Respimat inhaler manufacturer instructions dated December 2021, directed should be discarded three months after the inhaler is first used. The Prairie Lodge plan of correction document dated September 11, 2023, indicated medication cart audits would be completed twice monthly for three months to remove expired medications and determine if opened medications are labeled appropriately. The frequency of ongoing audits	{01890}		

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{01890}	Continued From page 29 would be determined by the facility quality assurance and performance improvement (QAPI) program. An audit tool provided by executive director of operations (EDO)-P on November 15, 2023, indicated medication cart audits had occurred every other week beginning on September 29, 2023. However, the tool did not list any findings of the audits. The licensee's Storage of Medications policy dated August 1, 2021, indicated the registered nurse (RN) must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the [resident's] medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion and other considerations. Based on this assessment, the RN would develop an individualized medication management plan for the resident that would address storage of the resident's medications. No further information provided.	{01890}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	{01970}		

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{01970}	Continued From page 30 This MN Requirement is not met as evidenced by: No further action required.	{01970}		
{02350} SS=F	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: No further action required.	{02350}		

Electronically Delivered

September 11, 2023

Licensee
The Prairie Lodge at Earle Brown
6001 Earle Brown Drive
Brooklyn Center, MN 55430

RE: Project Number(s) SL20315015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 28, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

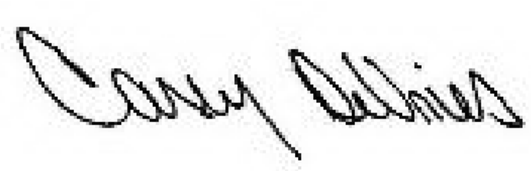
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	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: SL20315015-0 On July 24, 2023, through July 28, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 44 active residents; 42 of whom received services under the Assisted Living with Dementia Care license. An immediate correction order was identified on July 27, 2023, issued for SL20315015-0, tag identification 1760. On July 28, 2023, the immediacy of correction order 1760 was removed. The scope and severity remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in	0 510		

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0 510	Continued From page 2 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for two of three unlicensed personnel ((ULP)-B and 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C During observation on July 25, 2023, between 8:56 a.m. and 10:29 a.m., the surveyor observed ULP-C administer medications to four residents and perform cares to one resident. The surveyor began observing ULP-C set up medications for R11. While popping a medication from the bubble pack, a white, round pill fell on the mouse pad on top of the medication cart. ULP-C picked up the pill with bare hand to place it into the medication cup. Without hand hygiene, ULP-C approached R11 sitting at the dining room table after breakfast. ULP-C donned (applied) gloves then placed the needle on the insulin pen without wiping the top of the pen with an alcohol wipe.	0 510		

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0 510	Continued From page 3 Without cleaning R11's skin, ULP-C injected the insulin in the right bicep. This same process was repeated for the second insulin administered to R11. ULP-C returned to the medication cart, put items back and hand sanitized before setting up R12's medications. Upon entry of R12's room, ULP-C did not perform hand hygiene or don gloves. ULP-C administered two different insulins using the same technique as R11 (no alcohol wipe to insulin pens or resident's skin). Without hand hygiene, ULP-C returned to the medication cart to put items away, touched the computer, and looked for R12's creams by opening medication cart drawers. ULP-C found the lidocaine 2% jelly, donned gloves without hand hygiene, and walked back into R12's room to apply the jelly to the tip of R12's penis. Once completed, ULP-C walked out of the room with gloves on, holding the lidocaine jelly. Once lidocaine jelly was placed on medication cart, ULP-C doffed (removed) her gloves and hand sanitized. ULP-C then set up medications for R4. ULP-C donned gloves in R4's room and administered R4's medications. ULP-C assisted R4 with a transfer using a lifting device to place R4 on the toilet. ULP-C doffed gloves, went to the medication cart to return inhaler then went back into R4's room without hand hygiene. Once back in R4's room, ULP-C donned gloves to assist ULP-E who was assisting R4, but help wasn't needed so ULP-C doffed gloves, and returned to medication cart. ULP-C hand sanitized prior to setting up R23's medications. Once R23's medications were set up, ULP-C entered R23's room to administer medications. ULP-C returned to cart without hand hygiene. During this timeframe, surveyor did not observe ULP-C wash hands with soap and water. During observation on July 25, 2023, at 11:56	0 510		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

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0 510	Continued From page 4 a.m., ULP-C obtained insulin and glucometer kit to check R11's blood sugar prior to lunch. ULP-C donned gloves, approached R11 who was sitting at the dining room table, wiped his finger with an alcohol wipe, pricked his finger and used that alcohol wipe to wipe the first drop of blood away. ULP-C then placed that bloody wipe on the dining room table. Before administering insulin, ULP-C did not clean the insulin pen or R11's skin with an alcohol wipe. ULP-C doffed gloves and hand sanitized. ULP-C placed the glucometer kit back into the medication cart. The surveyor did not observe ULP-C sanitize the table before lunch was served to multiple residents. Surveyor asked if the glucometer kit was R11's or the facilities, ULP-C stated it was facilities and because R11's Freestyle Libre sensor was not working, she had to use it. During interview on July 25, 2023, at 12:00 p.m., ULP-C stated she did not use an alcohol wipe for insulin administration. ULP-C stated she was trained to change gloves between residents and before medication set up. She was also trained to always have gloves on during insulin administration. When surveyor pointed out she did not have gloves on for R12's insulin administration, she said, "oh." Surveyor asked how many times one can hand sanitize before it was required to wash with soap and water. ULP-C stated she should wash hands after hand sanitizing twice. Surveyor explained hand washing was not observed during that time frame, and ULP-C stated she did not hand wash at all. ULP-C's Administration of Insulin Syringe-Sliding Scale document signed by a registered nurse (RN) on February 16, 2023, indicated ULP-C was competent to administer insulin which included cleansing site with an alcohol wipe.	0 510		

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0 510	Continued From page 5 ULP-C's training log printed July 25, 2023, indicated ULP-C received infection control training on August 7, 2022, through a module course. ULP-B On July 25, 2023, at 7:48 a.m., the surveyor observed ULP-B use hand sanitizer and don gloves at the medication cart, then proceed to R14's room. R14 had checked their own blood glucose level prior to ULP-B entering the room. ULP-B looked at result on glucometer, put glucometer away in R14's room, doffed gloves, donned a new pair of gloves without using hand hygiene, checked R14's blood pressure with equipment brought from medication cart, doffed gloves, donned another pair of gloves, assisted R14 with insulin administration, inhaler, and returned to the medication cart at 8:02 a.m. There, ULP-B doffed gloves and used hand sanitizer. ULP-B did not clean the shared blood pressure equipment or R14's blood glucose machine. On July 25, 2023, at 8:13 a.m., the surveyor observed ULP-B don gloves and check R7's blood glucose level in R7's room with R7's blood glucose machine from the medication cart. ULP-B doffed gloves, assisted with oral medications and water without performing hand hygiene. ULP-B then donned gloves to assist with nasal spray, doffed gloves, washed hands, gathered trash from room into a bag, disposed of bag in utility room, returned to medication cart, was summoned by R15 in dining room, assisted R15 back to his room by wheelchair, returned to medication cart at 8:31 a.m., and at that time, used hand sanitizer.	0 510		

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0 510	Continued From page 6 On July 25, 2023, at 10:32 a.m., the surveyor observed R9 walk up to medication cart and request medications. ULP-B did not perform hand hygiene. ULP-B assisted with oral medications, donned gloves, and attempted to check R9's blood glucose level with R9's blood glucose machine. There was an error message on the machine. ULP-B removed R7's blood glucose machine from the medication cart and attempted to check R9's blood glucose level with R7's machine. R7's machine also gave an error message and no result. R9 walked away from the medication cart refusing additional attempts. ULP-B put the two blood glucose machines back in the cases without cleaning them, returned them to the medication cart, doffed gloves, and used hand sanitizer. On July 27, 2023, at 2:30 p.m., ULP-B stated they received training to wash hands or use hand sanitizer before and after doing anything. ULP-B stated that would include before putting on gloves and after removing them before doing anything else. On July 25, 2023, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated all staff were trained to perform hand hygiene before setting up medications, before medication administration, and before and after gloves. She expected hands be washed with soap and water after using hand sanitizer 2-3 times. CNS-A stated staff were not instructed to test blood glucose and administer insulin in the common areas, they were supposed to perform those within the resident's rooms where a trash receptacle is available. CNS-A stated shared glucometer kits are supposed to be cleaned after use each time. CNS-A stated staff were trained to use an alcohol wipe on the insulin pen before applying the needle and to cleanse	0 510		

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0 510	Continued From page 7 the resident's skin before administration. The licensee's Hand Hygiene policy dated August 1, 2021, indicated hand washing shall be performed between [resident] cares and whenever direct physical contact with a [resident] takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: -before and after direct contact with a [resident]; -if moving from a contaminated body site to a clean body site during [resident] care; -after removing gloves or gowns; and -before eating and after using a restroom. The licensee's Procedure for Using Gloves policy dated August 1, 2021, indicated hands should be washed prior to applying gloves, and after removal of gloves. The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance last reviewed January 30, 2020, indicated staff should use an alcohol-based hand rub or wash with soap and water for the following: -immediately after touching a patient; -before moving from work on a soiled body site to a clean body site on the same patient; -after touching a patient or the patient's immediate environment; -after contact with blood, body fluids, or contaminated surfaces; and -immediately after glove removal. The Sanofi (manufacturer) Lantus Solostar Pen Guide, dated August 2022, directed to remove the pen cap with clean hands and to wipe the pen tip (rubber seal) with an alcohol swab before screwing on the needle.	0 510		

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0 510	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. Additionally, the licensee failed to post the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities, and information for reporting suspected maltreatment to the	0 550		

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0 550	Continued From page 9 Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This had the potential to affect licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During facility tour on July 24, 2023, at 11:00 a.m., the surveyor observed a bulletin board in the common area of both building one and building two lacked all of the required postings. Surveyor asked assistant executive director (AED)-D where the required postings were located and she stated, "right here," pointing to the bulletin board which had the activity calendar, menu, and contact information for Office of Ombudsman for Long-Term Care. Surveyor asked where the rest was located and she stated, "in the other house," referring to house two. House two's bulletin board contained the same information posted at house one. Surveyor observed plastic holders on the wall near the entrances of buildings one and two labeled "Grievance Forms". Building two had forms available but building one did not. The licensee's Complaint Policy and Procedure	0 550		

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0 550	Continued From page 10 dated August 1, 2021, lacked information regarding required postings. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee	0 650		

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0 650	Continued From page 11 records contained the required content for two of three employees (unlicensed personnel (ULP)-B and 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-B ULP-B was hired on August 18, 2004, under the former comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. On July 25, 2023, during continuous observation from 7:48 a.m. until 10:39 a.m., the surveyor observed ULP-B provide medication and treatment administration to multiple residents. ULP-B administered oral medications, eye drops, nasal inhalers, oral inhalers, a topical patch, insulin via pen injector, check blood glucose levels, check oxygen saturation, and check blood pressure. ULP-B's employee record included a Relias (software training system) transcript of courses assigned and completed, and trainings provided at staff meetings on February 15, 2023, and July 20, 2023, which included blood glucose testing, Freestyle Libre 14 day blood glucose testing, administering sliding scale insulin via a syringe, and oxygen and nebulizer training. ULP-B's	0 650		

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0 650	Continued From page 12 record however, lacked documentation of required competency training completed by a registered nurse (RN) for medication administration by route of oral, eye, nasal, sublingual, buccal, rectal, and subcutaneous via pen injector, compression stockings, ace wraps, continuous positive airway pressure machine (CPAP), bilevel positive airway pressure machine (BiPAP), orthotic braces, and wound care. On July 27, 2023, at 2:30 p.m., ULP-B stated she had been trained by a registered nurse on medication administration and was observed administering medications to residents by a registered nurse when she was hired in 2004 and also when Ecumen took over approximately one year later. ULP-B did not recall the specific training or who provided it related to compression stockings, ace wraps, CPAP, BiPAP, orthotic braces, or wound care, however, ULP-B stated they know and understand those skills and have been trained at some point during their twenty years of employment with licensee. ULP-C ULP-C was hired on April 29, 2002, under the former comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. On July 25, 2023, from 8:43 a.m., to 10:44 a.m., the surveyor observed ULP-C administer medications to multiple residents. On July 25, 2023, at 12:00 p.m., the surveyor observed ULP-C check a blood glucose and administer insulin. On July 25, 2023, at 12:00 p.m., ULP-C stated she had administered medications to residents	0 650		

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0 650	Continued From page 13 since she was hired. ULP-C's employee record included a Relias transcript of courses assigned and completed, and training provided at staff meetings on February 15, 2023, and July 20, 2023, which included blood glucose testing, Freestyle Libre 14 day blood glucose testing, administering sliding scale insulin via a syringe, and oxygen and nebulizer training. ULP-C's record however, lacked documentation of required competency training completed by a RN for medication administration by route of oral, eye, nasal, sublingual, buccal, rectal, and subcutaneous via pen injector, compression stockings, ace wraps, CPAP, BiPAP, orthotic braces, and wound care. On July 26, 2023, at 11:55 a.m., ULP-C stated she could not recall if she was at the February 15, 2023, meeting when training on insulin administration occurred. ULP-C did recall attending the July 20, 2023, staff meeting. On July 27, 2023, at 9:20 a.m., ULP-C stated when hired by the licensee, she recalled being trained on skills such as medications, transfer lift machines, compression socks, and showers. On July 26, 2023, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated they do hands on training and competency with new hire ULPs. CNS-A stated they had not completed a form for supervision and competency until recently. CNS-A stated there was documentation for new hires in Relias for their training and competency, but it might not exist for staff that have been with the licensee for longer than six months. The licensee's Training Documentation policy dated August 1, 2021, indicated a record of staff	0 650		

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0 650	Continued From page 14 training and competency would be maintained. The policy indicated each competency evaluation, training, retraining, and orientation would include the following documentation: - facility name and location; - facility license number; - training topic or training program; - training methodology; - date of the training and/ or competency evaluation; - total amount of time for the training and competency evaluation; - name and title of the instructor; - instructor's signature; - name and title of the competency evaluator; - competency evaluator's electronic signature; - evaluator statement attesting the result of the training; - name and title of the staff person completing the training; - staff person's signature; and - staff person statement attesting they completed the training as described. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650		
0 660 SS=E	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	0 660		

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0 660	Continued From page 15 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for two of three employees (clinical nurse supervisor (CNS-A)) and (unlicensed personnel (ULP-B)). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's Facility Tuberculosis (TB) Risk Assessment dated July 17, 2023, indicated licensee was low risk. The risk assessment also indicated baseline TB screening of all health care personnel was performed at the time of hire.	0 660		

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0 660	Continued From page 16 On July 24, 2023, at 10:20 a.m., during the entrance conference clinical nurse supervisor (CNS)-A stated licensee completed TB history and symptom screening and baseline screening at hire. CNS-A's employee record contained a chest Xray completed on April 29, 2022. The record lacked a TB history and symptom screening and baseline screening completed at the time of hire. ULP-B's employee record contained a T-SPOT TB blood test result completed on October 14, 2015. The record lacked a TB history and symptom screening and baseline screening completed at the time of hire. The Minnesota Department of Health's (MDH) Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated baseline TB screening is required at the time of hire for all health care personnel to include: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. Also indicated, a chest Xray alone is not acceptable documentation. You either need: - documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test; and - a chest Xray with provider evaluation after that date. or - documentation of refusal of both the two-step TST and IGRA; and - followed by a new chest Xray and provider evaluation.	0 660		

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	20315	A. BUILDING: _____ B. WING _____	07/28/2023

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0 660	Continued From page 17 On July 25, 2023, at 1:20 p.m., CNS-A stated she understood the TB requirement and at hire she thought she had completed all requirements. On July 25, 2023, at 1:30 p.m., assistant executive director (AED)-D stated that she had provided all what was available in CNS-A's file. The licensee's TB Prevention and Control policy updated December 12, 2019, indicated licensee will establish and maintain a TB prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and MDH. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 18 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP)with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee's undated EPP had a collection of a risk analysis tools and policies addressing fire, fire drills and equipment, bomb threat, heat/humidity, electrical outage and heating, ventilation and air conditioning (HVAC) failure, severe winter weather, chemical exposure, sheltering in place, and evacuation. The licensee's undated EPP lacked the following	0 680		

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0 680	Continued From page 19 content: - Process for Emergency Program Collaboration; - Subsistence Needs for Staff and Patients (residents); - Procedures for Tracking of Staff and Patients; - Policies and Procedures for Sheltering; - Policies and Procedures for Medical Documents; - Policies and Procedures for Volunteers; - Arrangement with Other Facilities; - Roles under a Waiver Declared by Secretary; - Development of Communication Plan; - Names and Contact Information; - Emergency Officials Contact Information; - Primary/Alternative Means for Communication; - Methods for Sharing Information; - Sharing Information on Occupancy Needs; - Emergency Prep Training and Testing; and - Integrated Health Systems. On July 26, 2023, at 1:15 p.m., assistant executive director (AED)-D stated the licensee's EPP was missing required information, even though it was created with the assistance of their board. AED-D stated the board meets every other month and would review the EPP and add the missing required elements. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee] will implement the Emergency Management Program as soon as the agency becomes aware of the existence of an emergency."	0 680		

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0 680	Continued From page 20 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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).	0 800		

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0 800	Continued From page 21 Findings include: On July 25, 2023, approximately from 10:00 a.m. to 12:30 p.m., survey staff toured the facility with the environmental services director (ESD)-F, the corporate facilities manager (CFM)-G, and the corporate maintenance technician (CMT)-H. The following was observed: Building 6011 Apartment E2 had significant amounts of damage to the walls, doors, and door trim. ESD-F stated that the resident in E2 used an electric scooter to navigate around the apartment and the facility, leaving significant damage to the building elements due to the speed and maneuverability limitations of the scooter. Apartment E3 had several medium size cylinders of oxygen that were not being stored properly. Oxygen needs to be stored in racks or secured with chains according to manufacturer and supplier recommendations. The oxygen in the resident's room was not properly stored. The laundry room floor had signs of water damage. The floor material was raised and no longer adhered to the subfloor along the wall adjacent to one of the washing machines. Other pieces of the flooring in that area were stained and some had a white residue on them. The employee breakroom had a J-box with no cover, and an internet/phone cable was hanging out of it onto the floor. The door to the employee lounge was missing the wood trim piece and had several nails protruding from the door frame into the employee area.	0 800		

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0 800	Continued From page 22 There was a hole in the assistant executive director's office closet ceiling which exposed the attic insulation and had the potential to compromise the fire rating of the ceiling assembly. The sprinkler room was missing the bottom two feet of drywall behind the sprinkler system. ESD-F stated that it was an outside wall and had water damage due to an ice dam issue the building had in March 2023. The main entrance lobby had parts of the drywall removed on the exterior wall exposing the vapor barrier and batt insulation. ESD-F stated that the damage was due to the same ice dam issue the building had in March 2023. Building 6001 The ceiling in the main entrance lobby was damaged adjacent to the mailboxes. The trim was pulling away from the drywall and parts of the ceiling texture had fallen. Apartment E1 had recently been vacated and was in the process of being renovated. There was extensive damage to the carpet and the walls. The carpet was heavily stained throughout the apartment. The drywall around the closet and bathroom had been damaged and broken. The carpet in the employee lounge was heavily soiled and stained throughout the space. The wall corners at the uncased opening behind the nurse's station were heavily damaged. Damage was more extensive than typical wear and tear. There were large areas where the drywall was broken and trim pieces had been bent by heavy impact.	0 800		

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0 800	Continued From page 23 The entrance door to Pod B had the bottom two feet of trim ripped off exposing the door frame beneath. The wood trim for the door to apartment A2 was popping off the wall and had several nails exposed and protruding into the circulation space. ESD-F, CFM-G, and CMT-H visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (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	0 810		

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0 810	Continued From page 24 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to provide required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: On July 25, 2023, approximately from 10:00 a.m. to 12:30 p.m., survey staff toured the facility with the environmental services director (ESD)-F, the corporate facilities manager (CFM)-G, and the corporate maintenance technician (CMT)-H. It	0 810		

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0 810	Continued From page 25 was observed that the posted evacuation diagrams in the facility did not include the number and location of resident rooms. ESD-F visually verified this deficient finding at the time of discovery. A record review and interview were conducted on June 21, 2023, at approximately 1:00 p.m. with ESD-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, ESD-F verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, ESD-F stated the licensee did not have documentation on employee training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, ESD-F stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 26 (21) days.	0 810		
01060 SS=F	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. (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	01060		

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01060	Continued From page 27 (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 interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one hospitalized resident (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 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: R4 was admitted for services on April 1, 2019, with diagnoses including disease of spinal cord, constipation, osteoarthritis, cerebral palsy, and chronic obstructive pulmonary disease (COPD). R4's Service Plan signed April 10, 2023, indicated R4 received services including assistance with exercises, bathing, bed mobility, behavior, dressing, grooming, transfers, medication administration, toileting, and safety checks. R4's Progress Notes dated March 29, 2023, at 5:31 p.m., indicated clinical nurse supervisor (CNS)-A observed R4 wheezing and struggling to	01060		

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01060	Continued From page 28 take breaths with each spoken word. R4 requested to be sent to the hospital. R4's Progress Note dated March 29, 2023, at 8:16 p.m., indicated registered nurse (RN)-O received a call from the hospital stating R4 was admitted, and resident needed to be placed on leave of absence (LOA). R4's Progress Note dated April 3, 2023, at 2:39 p.m., indicated CNS-A was informed by the hospital that R4 was admitted for COPD exacerbation and R4 was receiving oxygen therapy. R4's Progress Note dated April 5, 2023, at 10:28 a.m., indicated CNS-A received discharge paperwork with a new diagnosis of COPD exacerbation and a new order for an inhaler and 1 liter (L) of oxygen as needed. R4's Progress Note dated April 5, 2023, at 11:39 a.m., indicated R4 returned to the facility. R4's records lacked evidence of a written notice provided to the resident, that contained, at a minimum: - the reason for the relocation; - 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	01060		

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01060	Continued From page 29 information for the agency to which the resident may submit an appeal. During an interview on July 27, 2023, at 1:41 p.m., CNS-A stated when a resident goes to the hospital, they provide a face sheet, documentation of last medications administered, and notify family. CNS-A was unaware the required information needed to be given to any resident and/or their designated representative upon emergency relocation. During an interview on July 27, 2023, at 1:42 p.m., executive director of operations (EDO)-P indicated R4 and his son contacted OOLTC on their own, and she also indicated they don't use any written notification form with the required information listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under	01290		

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01290	Continued From page 30 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 a background study was submitted and received in affiliation with the assisted living licensee for two of six employees (unlicensed personnel (ULP)-K and ULP-L). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-K ULP-K began employment with the licensee on December 9, 2019, under the former comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. The employee roster presented to surveyors by assistant executive director (AED)-D, indicated ULP-K to be a full-time active employee working 60 to 79 hours per pay period. ULP-K's record included Background Study Clearance dated October 30, 2015, and affiliated with agency identification number 21399.	01290		

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	20315	A. BUILDING: _____ B. WING _____	07/28/2023

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01290	Continued From page 31 ULP-K's record lacked evidence the licensee submitted a background study for ULP-K under the licensee's assisted living with dementia care license and affiliated to the licensee's health facility identification (HFID) number. ULP-L ULP-L began employment with the licensee on August 22, 1993, under the former comprehensive license and began providing services under the assisted living with dementia care license on August 1, 2021. The employee roster presented to surveyors by AED-D, indicated ULP-L to be a full-time active employee working 60 to 79 hours per pay period. ULP-L's record included Background Study Clearance dated November 20, 2018, and affiliated with agency identification number 21399. ULP-L's record lacked evidence the licensee submitted a background study for ULP-L under the licensee's assisted living with dementia care license and affiliated to the licensee's HFID number. On July 25, 2023, at 1:46 p.m., assistant executive director (AED)-D and the surveyor observed the licensee's NetStudy 2.0 employee roster. The roster lacked the presence of ULP-L and ULP-K indicating they were not affiliated with the licensee's current HFID. On July 25, 2023, at 2:45 p.m., AED-D stated they were responsible for completing background studies, and thought the affiliation from the licensee's old HFID to the new HFID was automatic. AED-D was not sure if employees who worked for licensee before August 1, 2021, had	01290		

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01290	Continued From page 32 their backgrounds affiliated to the current HFID. AED-D stated they would consult with corporate human resources and return with additional information. Licensee's Background Checks policy dated August 1, 2021, indicated all employees and regularly scheduled volunteers of the licensee with direct contact will undergo a background study through Department of Human Services (DHS). Also indicated only those with satisfactory results will work with licensee's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=D	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	01440		

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01440	Continued From page 33 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 the registered nurse (RN) provided direct supervision of staff performing delegated tasks within 30 calendar days after tasks were delegated for one of three unlicensed personnel ((ULP)-J). 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: ULP-J started employment with the licensee February 27, 2023. ULP-J's employee file had a New Hire Competency Skills Checklist dated July 27, 2023, and a Relias (software training system) Transcript dated between March 2, 2023, and March 16, 2023. R5's medication administration record (MAR) dated July 1, 2023, through July 24, 2023, indicated ULP-J administered medications to R5 on July 22, 2023, and July 23, 2023.	01440		

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01440	Continued From page 34 ULP-J's employee record lacked direct supervision performing delegated tasks within 30 calendar days after the date on which the ULP first performed delegated tasks for residents and thereafter as needed based on performance. On April 25, 2023, at 11:20 a.m., clinical nurse supervisor (CNS)-A stated all employees are supervised within 30 calendar days from the date of first performing a delegated task and thereafter as needed based on performance. CNS-A also stated ULP-J's record lacked documentation of supervision by the RN and they could not recall if it was completed or not. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated January 27, 2023, indicated "Both licensed and unlicensed staff will be supervised by designated supervisors to ensure that the staff is performing their job duties competently, consistently and according to standards that may apply. Supervision of ULPs by an RN will be done by direct supervision of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks". No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=E	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	01620		

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01620	Continued From page 35 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for three of six residents (R2, R16, R17) and failed to conduct an ongoing resident reassessment and monitoring, as needed based on changes in the needs of the resident for one of six residents (R5). Additionally, licensee failed to ensure the RN conducted a change in condition assessment for one of one resident (R4) upon return from hospital. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 36 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN ASSESSMENT R2 R2 admitted to the licensee on November 21, 2022. R2's diagnoses included Alzheimer's disease, type 2 diabetes mellitus, difficulty in walking, and acute and chronic respiratory failure. R2's Service Plan signed January 31, 2023, indicated R2 received assistance with linen change, bathing, dining escort, dressing, grooming, oral cares, housekeeping, transfer assist, medication administration, oxygen safety check, and ongoing monitoring and review. R2's record included 90-day nursing assessments dated January 13, 2023, April 12, 2023, and July 25, 2023. The assessment completed on July 25, 2023, indicated 104 days had passed between assessments. R16 R16 was admitted for services under the comprehensive home care license on April 25, 2019, and began receiving assisted living services on August 1, 2021. R16's diagnoses included hemiplegia and hemiparesis following unspecified	01620		

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01620	Continued From page 37 cerebrovascular disease affecting right dominant side, hypertension, and major depressive disorder. R16's Service Plan signed March 15, 2023, indicated R16 received assistance with linen change, laundry, bathing, dining and activities escort, dressing, grooming, nail care, oral cares, housekeeping, transfer assist, ambulation, toileting, repositioning, medication administration, nebulizer assistance, and ongoing monitoring and review. R16's record included 90-day nursing assessments dated March 15, 2023, and June 19, 2023. The assessment completed on June 19, 2023, indicated 96 days had passed between assessments. R17 R17 admitted to the licensee for assisted living services on June 9, 2023. R17's diagnoses included schizoaffective disorder, bipolar type, back and hip pain, obstructive sleep apnea, prediabetes, osteoarthritis, anxiety disorder, and chronic obstructive pulmonary disease (COPD). R17's Service Plan signed June 9, 2023, indicated R17 received assistance with linen change, activities reminders, dining reminders, dining set-up, bathing, dressing, grooming, transfers, toileting, nail care, oral care, pain management, housekeeping, bed making, laundry, medication administration, safety checks, and ongoing monitoring and review. R17's record included an initial assessment completed on June 9, 2023, and a 14-day nursing	01620		

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01620	Continued From page 38 assessment completed on June 29, 2023. The 14-day assessment was due on June 23, 2023. On July 27, 2023, at 1:29 p.m., clinical nurse supervisor (CNS)-A stated initial assessments should be completed on the day of admission, the next assessment of a new resident should be completed within 14 days, and ongoing assessments should be completed every 90 days. The surveyor inquired why R2's ongoing assessments was conducted after 90 days. CNS-A stated she was the only RN to complete all the licensee's resident assessments, and this assessment was one she could not get to in time. In addition, CNS-A stated assessment could have been late if the assessment was due on a weekend, holiday, or when she took vacation. CHANGE IN CONDITION R4 admitted to licensee on April 1, 2019. R4's diagnoses included disease of spinal cord, constipation, osteoarthritis, cerebral palsy, and chronic obstructive pulmonary disease (COPD). R4's Service Plan signed April 10, 2023, indicated R4 received services including assistance with exercises, bathing, bed mobility, behavior, dressing, compression stockings, grooming, transfers, medication administration, toileting, and safety checks. R4's Progress Note dated April 5, 2023, at 10:28 a.m., indicated CNS-A received paperwork from hospital indicating R4 had a new diagnosis of COPD exacerbation, new medication order for Advair inhaler, and 1 liter (L) of oxygen as needed (PRN). R4's Progress Notes dated April 5, 2023, at 11:39	01620		

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01620	Continued From page 39 a.m., indicated R4 returned from the hospital. CNS-A obtained R4's vital signs (blood pressure, pulse, oxygen saturation, temperature, and respirations). CNS-A indicated R4 had no pain, and his voice was cracked, so they advised R4 to drink more water. R4's record lacked a full RN assessment upon his return from the hospital. During interview on July 27, 2023, at 3:11 p.m., CNS-A stated she completed an in-person assessment on R4 when he returned from the hospital and documented that in the progress notes. She stated she did not complete a full RN assessment using the uniform assessment tool required under Minnesota Rules chapter 4659.0150. CNS-A stated she completed a 90-day RN assessment for R4 when she received his oxygen orders on May 19, 2023. R5 R5 was admitted for services under the comprehensive home care license on May 1, 2019, and began receiving assisted living services on August 1, 2021. R5's diagnoses included paranoid schizophrenia, anxiety, Lewy-body dementia, and hypertension. R5's service plan dated February 6, 2023, indicated R5 received services including linen change, escort to meals and activities, reminders and redirection, dressing, bathing, grooming, nail care, transfers, bed mobility, toileting, monthly vital signs, housekeeping, laundry, bed making, bed rails, oxygen management, medication management, mealtime set up, and safety checks.	01620		

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01620	Continued From page 40 On July 25, 2023, during continuous observation from 7:48 a.m. until 8:36 a.m., R5 sat in their Broda Chair (specialized wheelchair) at the breakfast table. R5 had one glass of apple juice, one glass of cranberry juice, and one glass of water at the table in front of them. R5 did not make any attempt to reach forward and drink any of the beverages during that time. On July 25, 2023, at 8:36 a.m., the surveyor observed dining assistant (DA)-Q brought R5 a plate of food prepared to be mechanical soft, sat down next to R5, and provided R5 with total assistance of eating and drinking the entire meal. On July 25, 2023, at 9:10 a.m., the surveyor observed ULP-B assist R5 with medications. ULP-B crushed medications and mixed them with applesauce, spoon fed the medications to R5, and provided total assist for R5 to drink from a water glass. On July 25, 2023, at 10:39 a.m., ULP-B stated R5 used to feed herself but had declined recently. ULP-B stated it had been at least four months that the dietary staff were helping with feeding R5 after they serve all of the other residents. On July 27, 2023, at 2:15 p.m., surveyors observed R5 seated in R5's Broda chair at her designated place at the dining room table. During a conversation with R5, the surveyor asked if R5 could lift her arms up and reach a facial tissue box that was on the table where a plate would set at mealtime. R5 was able to reach forward but not reach the table and R5's hand motions indicated R5 may not be able to purposefully grasp eating utensils or glasses of fluids. On July 27, 2023, at 2:30 p.m., ULP-B stated	01620		

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01620	Continued From page 41 transfers for R5 were more challenging than they used to be. ULP-B stated R5 used to transfer with one person but now usually needs two people and a transfer belt to transfer. ULP-B stated R5 would be a very heavy transfer with one person. R5's most recent assessment completed on May 3, 2023, by licensee's regional registered nurse, (RN)-R, indicated R5 needed physical assist of one for transfers, R5 was one assist with a gait belt, R5 received physical assist of one for ambulation, R5 had a regular texture diet, and R5 needed verbal reminders and set up with dining. On July 27, 2023, at 2:45 p.m., CNS-A stated R5 had good and bad days with their health and did not always participate in cares at a consistent level. CNS-A stated they were not aware staff were feeding R5 full meals, serving mechanical soft textured foods, and transferring with assist of two at times. The licensee's Initial and Ongoing Nursing Assessment of Residents policy effective August 1, 2021, indicated nursing assessments are completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. Also indicated ongoing assessment: completed periodically but no less than every 90-days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 42 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided as required in the current service plan for one of five residents (R5). In addition, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and the resident or resident's designated representative to document agreement on the services to be provided for two of five residents (R8, R16). 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	01640		

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01640	Continued From page 43 cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: SERVICE PLAN IMPLEMENTATION R5 R5 was admitted for services under the comprehensive home care license on May 1, 2019, and began receiving assisted living services on August 1, 2021. R5's service plan dated February 6, 2023, indicated R5's services included oxygen assistance. The description included that R5 had an order for oxygen (O2) as needed to use if R5's oxygen saturation level (O2 sats) was below 90 percent (%). The service plan indicated unlicensed personnel (ULP) would assist R5 with oxygen, check O2 sats, assist to place oxygen cannula and would find specific instructions on the medication administration record (MAR). R5's MAR dated July 1 to July 24, 2023, indicated if R5's O2 sats fell below 90%, R5 may use O2 at two (2) liters per nasal cannula. The MAR lacked a schedule of specific times for ULPs to check O2 sats for R5. On July 25, 2023, at 9:27 a.m., the surveyor observed ULP-B check R5's O2 sats. ULP-B had given R5 medications at 9:00 a.m., then given medications to another resident, before returning to R5 at 9:27 a.m. ULP-B stated they forgot about checking O2 sats before as O2 sats were not	01640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

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01640	Continued From page 44 listed on the MAR for them to enter a value, but ULP-B stated they knew the O2 sats needed to be checked. ULP-B stated the O2 sats are signed off at the end of their shift on the iPad but due to be checked at the time of medication pass. R5's service checkoff list dated July 1 to July 31, 2023, printed on July 25, 2023, indicated R5's O2 sats were to be checked every day at 8:00 a.m., 4:00 p.m., and 11:00 p.m. The service checkoff list indicated R5 had an order for as needed oxygen to use if R5's O2 sats were below 90%. As of July 25, 2023, the 8:00 a.m., readings for R5's oxygen saturation had been documented as complete with initials of ULP and a number indicating what R5's O2 sats were 11 out of 24 times. As of July 25, 2023, the 4:00 p.m., readings for R5's oxygen saturation had been documented as complete with initials of ULP and a number indicating what R5's O2 sats were 18 out of 24 times. As of July 25, 2023, the 11:00 p.m., readings for R5's oxygen saturation had been documented as complete with initials of ULP and a number indicating what R5's O2 sats were 14 out of 24 times. As of July 25, 2023, the service checkoff list indicated, O2 sats for R5 were missed a total of 29 times out of 72. In addition, the service checkoff list lacked documentation of any missed or cancelled events where O2 sats were noted. On July 25, 2023, at 12:40 p.m., clinical nurse supervisor (CNS)-A, stated when a resident has as needed oxygen, they would expect to see O2	01640		

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01640	Continued From page 45 sats on the MAR to check them and document three times every day. CNS-A states they have seen ULPs checking R5's O2 sats before. SERVICE PLAN REVISION R8 R8 was admitted for services under the comprehensive home care license on July 10, 2019, and began receiving assisted living services on August 1, 2021. R8's Service Plan with effective date of January 16, 2023, was identified by executive director of operations (EDO)-P as R8's most recent signed service plan. The service plan included 19 identified services R8 received. R8's Service Plan Agreement with effective date of July 26, 2023, identified as the current service plan with all current services R8 received lacked authentication by the licensee, resident, or resident's designated representative. R8's current service plan included 26 identified services, 11 revised or started after January 16, 2023, and indicated a $1,493.56 increase in the monthly fee for services provided compared to R8's authenticated service plan identified above. R16 R16 was admitted for services under the comprehensive home care license on April 25, 2019, and began receiving assisted living services on August 1, 2021. R16's Service Plan with effective date of March 15, 2023, was identified by EDO-P as R16's most recent signed service plan. The service plan included 72 identified services R16 received.	01640		

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01640	Continued From page 46 R16's Service Plan Agreement with effective date of July 27, 2023, identified as the current service plan with all current services R16 received lacked authentication by the licensee, resident, or resident's designated representative. R16's current service plan included 71 identified services, 13 revised or started after March 15, 2023. The new services included fasting blood glucose monitoring three times daily at 7:05 a.m., 11:30 a.m., and 4:30 p.m., which had been added to the service plan on April 28, 2023. The revisions to the service plan indicated a $1,248.85 increase in the monthly fee for services provided compared to R16's authenticated service plan identified above. The licensee's policy, Content of Service Plans, dated August 1, 2021, indicated all residents would have an up-to-date service plan identifying services to be provided based on assessment. Service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident. In addition, the facility will implement and provide all services required by the current service plan unless unable for reasons such as resident refusal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

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01650	Continued From page 47 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of six residents (R17). 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	01650		

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01650	Continued From page 48 situation has occurred only occasionally). The findings include: R17's diagnoses included schizoaffective disorder, bipolar type, back and hip pain, obstructive sleep apnea, prediabetes, osteoarthritis, anxiety disorder, and chronic obstructive pulmonary disease (COPD). R17's Service Plan signed June 9, 2023, indicated R16 received assistance with linen change, activities reminders, dining reminders, dining set-up, bathing, dressing, grooming, transfers, toileting, nail care, oral care, pain management, housekeeping, bed making, laundry, medication administration, safety checks, and ongoing monitoring and review. R17's Service Plan lacked the following required content: - the fees for services. On July 24, 2023, at 10:30 a.m., executive director of operations (EDO)-P stated the clinical nurse supervisor (CNS) completes and updates all service plans based on their nursing assessments. On July 27, 2023, at 1:29 p.m., CNS-A stated, the service plan data generates from the nursing assessment. CNS-A was unsure how to resolve if something was missing and did not notice the fees missing from R17's service plan. The licensee's Contents of Service Plan policy dated August 1, 2021, indicated the service plan would include fees for service. No further information was provided.	01650		

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01650	Continued From page 49 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=I	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of four unlicensed personnel ((ULP)-B, ULP-C) administered medications per the licensee's policy and procedure, and failed to administer medications as prescribed for three of twenty-six residents (R11, R12, and R8) observed during medication administration. 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	01760	On July 28, 2023, the immediacy of correction order 1760 was removed. The scope and severity remained unchanged.	

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01760	Continued From page 50 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: R11 R11 admitted on October 17, 2022, with diagnoses of diabetes type 2 with diabetic neuropathy, hypertensive heart and chronic kidney disease, atrial fibrillation, and congestive heart failure. R11's unsigned Service Plan printed on July 25, 2023, indicated R11 received medication management and insulin administration three times daily effective April 20, 2023. R11's record included glycated hemoglobin (A1C) results which measures the average blood sugar in the body two to three months, was as follows: -May 3, 2023, was 11.1 mg/dL (milligrams per deciliter). R11's provider orders dated May 8, 2023, ordered to start glargine insulin (Lantus Solostar) insulin, inject 38 u SQ twice a day for DM. R11's provider orders dated May 11, 2023, ordered to start Trulicity 3 mg/0.5 ml, inject 0.5 ml SQ every week for diabetes mellitus (DM). The order also indicated to start Humalog, inject 15 u SQ three times a day with meals for DM. R11's Medication Administration Record (MAR) dated July 2023, indicated: -Humalog 100 unit (u)/ milliliter (ml) injection, inject 15 u subcutaneously (SQ) three times a day with meals; -Lantus Solostar 100 u/ml injection, inject 38 u	01760		

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01760	Continued From page 51 SQ twice a day for DM; and -Trulicity 3 mg/0.5 ml injection, inject 0.5 ml SQ once weekly. On July 25, 2023, at 8:49 a.m., the surveyor observed ULP-C check the MAR on the computer, on the medication cart, for dosing instructions of Humalog and Lantus. ULP-C gathered the medication and needles and walked away from the MAR to R11 who was sitting at the dining room table. ULP-C then dialed 15 units of Humalog (correct dose) and applied the needle. Without priming the needle or wiping R11's arm with alcohol wipe, ULP-C administered the insulin. ULP-C then dialed 38 units of Lantus insulin (correct dose) and repeated the same process to R11. The surveyor did not observe ULP-C conduct three checks prior to dosing the medication. On July 25, 2023, at 11:56 a.m., the surveyor observed ULP-C check R11's MAR on the computer on the medication cart in the dining room of the assisted living then ULP-C gathered the glucometer and the Humalog FlexPen with needle and walked away from the MAR. ULP-C dialed 6 u of Humalog insulin and prepared to administer to R11. The surveyor intervened and asked ULP-C to check the MAR again. ULP-C went to the medication cart, checked the MAR, then dialed up 15 u of Humalog insulin. Without priming the needle, or wiping R11's arm with alcohol wipe, ULP-C administered the insulin to R11. The surveyor did not observe ULP-C conduct three checks prior to dosing the medication. R11's record dated May 1, 2023, through July 25, 2023, indicated ULP-C administered insulin to R11 on 34 occurrences.	01760		

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01760	Continued From page 52 R12 R12 admitted on November 12, 2019, with diagnoses of type two diabetes mellitus with diabetic polyneuropathy, and chronic kidney disease. R12's unsigned Service Plan printed on July 25, 2023, indicated R12 received medication management and insulin administration four times daily effective January 19, 2022. R12's prescriber orders dated June 28, 2023, indicated to inject insulin aspart flexpen 6 u SQ three times a day with meals. R12's prescriber orders dated July 7, 2023, indicated to discontinue previous orders for Basaglar and start Basaglar 28 u SQ twice a day for DM. R12's MAR dated July 2023, indicated R12 received: -Basaglar KwikPen 100 u/ml injection, inject 25 u twice daily from July 1, 2023, through July 10, 2023; -Basagalar KwikPen 100 u/ml injection, inject 28 u twice daily from July 11, 2023, through July 24, 2023; -insulin aspart flexpen injection, inject 6 u three times a day with meals. On July 25, 2023, at 9:11 a.m., the surveyor observed ULP-C check R12's MAR at the medication cart, gather both insulin aspart and Basaglar insulin pens and walk to R12's room. ULP-C administered R12's oral medications then dialed 25 units of Basaglar insulin (incorrect dose), and applied the needle to the pen. Without priming the needle of the pen or wiping R12's arm	01760		

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01760	Continued From page 53 with an alcohol wipe, ULP-C administered the insulin. ULP-C then dialed insulin apart 6 u (correct dose) and repeated the same process to R12. R12's record included glycated hemoglobin (A1C) results were as follows: -June 24, 2022, was 7.7 mg/dL; -December 14, 2022, was 7.5 mg/dL; and -June 14, 2023, was 9.0 mg/dL R12's record dated May 1, 2023, through July 25, 2023, indicated ULP-C administered insulin to R12 on 34 occurrences. During an interview on July 25, 2023, at 12:00 p.m., ULP-C stated they were trained how to administer medications when first hired in 2002 and had been a medication passer since. ULP-C stated she was taught to only prime a brand-new insulin pen, then thereafter, it wasn't necessary. ULP-C stated she used the pharmacy label of any insulin pen to determine how much insulin to draw up while with the resident. ULP-C further stated when there were dose changes with resident medications the RN would inform her of the change. After speaking with surveyor, ULP-C indicated going forward, she would use the dose indicated on the MAR, not on the pharmacy label. When ULP-C was asked why she did not check the label against the MAR before heading to the resident room, ULP-C stated she had done it, however, the surveyor did not observe ULP-C conduct three checks prior to dosing the medication. ULP-C's employee record contained no evidence of initial training or competency evaluations related to medication administration including insulin administration upon hire on April 29, 2002.	01760		

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01760	Continued From page 54 ULP-C's training record indicated ULP-C participated in a staff meeting on February 16, 2023, where Administration of Insulin Syringe - Sliding Scale was a topic of training. On July 26, 2023, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated they provided training on insulin administration to all ULPs in a staff meeting on February 16, 2023. CNS-A stated they presented information to all attendees and then demonstrated use of equipment with two employees at a time with the medication cart using resident supplies. However, return demonstration did not occur with resident, rather, ULPs verbally relayed the procedural steps they would follow in the situation of insulin administration. On July 25, 2023, during two medication administration observations from 8:49 a.m. to 10:34 a.m., and 11:55 a.m. to 12:00 p.m., the surveyor observed ULP-C administer medications to four residents. During that time, although ULP-C verbalized she was doing her three checks while setting up the medications, the surveyor did not observe ULP-C complete the three checks to confirm labels to the MAR for any of the four residents. ULP-C stated many times that she was behind on medication administration because they only had two staff working. ULP-B ULP-B started employment with licensee August 18, 2004, under the former comprehensive license and started providing assisted living services August 1, 2021. ULP-B's training record indicated ULP-B completed training for oxygen use, blood glucose	01760		

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01760	Continued From page 55 testing, nebulizer, and administration of sliding scale insulin, however, lacked documentation of any training or competency related to medication administration. On July 26, 2023, at 11:45 a.m., ULP-B stated when she was hired in 2004, she received training on medication administration, shadowed other staff, and demonstrated competency for a nurse. The licensee maintained no record of the training. R3 During observation and interview on July 24, 2023, at 10:20 a.m., R3 was waiting near the front door of the assisted living building waiting for her Metro Mobility ride. R3 indicated she had not received her medication yet and asked staff to quick set them up. ULP-B approached the medication cart which was near R3. ULP-B opened one of the drawers of the medication cart and took out a clear envelope used to crush medications with a white round pill inside of it. ULP-B placed the medication in the medication cup. Surveyor asked what the medication was, and ULP-B stated it was a hydromorphone and that she had set it up earlier because R3 informed her that she would be leaving at this time. ULP-B then proceeded to give R3 the pill from the clear envelop and R3 consumed it before leaving. ULP-B stated she set the medication up because R3 would have been "screaming, and anxious if she didn't receive her pill quick enough." ULP-B also stated, "Other than that, I would not do that. I would normally label it and date it with her information if it was going with her. But she gets very anxious so that way it was ready for her." The clear envelope was not labeled with any of R3's information, therefore, ULP-B was unable to perform three checks and	01760		

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01760	Continued From page 56 ensure the 6 rights of medication administration were met. R8 R8 admitted on July10, 2019, with diagnoses of alcoholic cirrhosis of liver without ascites, intracranial injury without loss of consciousness, major epilepsy, and hypertension. R8's unsigned Service Plan dated January 16, 2023, indicated R8 received medication management and medication administration four times daily. R8's MAR dated July 2023, indicated R8 received constulose (laxative) 10 G (gram)/ 15 ml solution, 15 ml by mouth twice daily at 8:00 a.m., and 4:00 p.m. On July 25, 2022, at 9:28 a.m., the surveyor observed ULP-B remove R5's bottle of robafen congest (cough expectorant) from the medication cart. ULP-B was preparing medications for R8. ULP-B did not look at the label on R5's robafen. The surveyor observed ULP-B pour 15 ml of robafen congest (cough expectorant) 200mg/ 10ml solution from a bottle labeled for R5. ULP-B proceeded to bring the medication to R8's room. Surveyor intervened as R8 raised the medication cup of red liquid so R8 would not ingest R5's medication. ULP-B returned to medication cart and poured 15 ml of contulose 10G/15 ml and brought it to R8. R8 refused the blue contulose. ULP-B brought the contulose back to the medication cart. On July 25, 2023, at 9:40 a.m., ULP-B stated they do not usually make mistakes. ULP-B stated they check the medication label with MAR three times and understood the six rights of medication	01760		

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01760	Continued From page 57 administration. ULP-B stated they received training on checking the label three times to confirm accuracy and following the six rights of medication administration. ULP-B stated they made the mistake because they got in a hurry because other residents were waiting for medications and were getting upset. On July 25, 2023, during continuous observation from 7:48 a.m. to 10:39 a.m., the surveyor observed ULP-B administer medications to twelve residents. During that time ULP-B did not complete three checks to confirm labels to the MAR for any of the twelve residents. ULP-B indicated she was aware of the three checks and six rights of medication administration but stated the medication cart and resident group ULP-B was working with on July 25, 2023, had the most medications and took so much time. ULP-B stated they had to work as quickly as they could and acknowledged they did not always complete three checks on each medication. On July 25, 2023, at 12:40 p.m., CNS-A stated ULPs should be doing three checks to compare the medication label with the MAR. CNS-A's expectation was that the ULPs follow six rights of medication administration at all times. CNS-A stated, "they are letting their nerves get the best of them" in response to notification of the medication errors. CNS-A further stated they expected ULPs to prime the insulin to 2 u, push out, then dial to dose, and ULPs are to clean the insulin top with alcohol before applying the needle and prior to insulin administration on the resident's skin. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, indicated unlicensed	01760		

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01760	Continued From page 58 personnel that satisfy the training requirements, have been determined competent to follow procedures may administer medications. In addition, medications would always need to be administered according to the "6 rights," including making sure they have the right person, right medication, right time, right route, right dose, and right documentation. The American Diabetes Association Position Statement titled Insulin Administration, dated January 1, 2003, provided direction to prime insulin pens with two units of insulin prior to dialing and administering the ordered dose of insulin. This procedure removes any air bubbles that may have accumulated in the pen. If not correctly primed the air bubbles decrease the amount of insulin administered. This leads to fluctuations in blood glucose results and increased stress on internal organs. No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a	01790		

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01790	Continued From page 59 medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was	01790		

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01790	Continued From page 60 completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee (unlicensed personnel (ULP)-B). 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-B ULP-B was hired on August 18, 2004, under the former comprehensive license and started to providing services under the assisted living with dementia care license on August 1, 2021. ULP-B's employee record lacked documentation of training and competencies for unplanned time away when the RN is not available.	01790		

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01790	Continued From page 61 On July 25, 2023, at 10:39 a.m., ULP-B stated her training was in 2004 and she did not recall specifically being trained on setting up medications for residents with unplanned time away. ULP-B stated if a resident went out, ULP-B would put their scheduled medications in an envelope and administer them before they left or when they arrived home from their outing. On July 25, 2023, at 12:40 p.m., CNS-A stated the ULPs have not been trained in medication administration for unplanned times away. CNS-A stated the ULPs would call triage for directions on what to do if a resident were going out and needed medications. CNS-A confirmed there are not nurses on site round the clock and residents do go on outings when they would need medications taken with them. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for three of	01880		

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01880	Continued From page 62 seven residents (R4, R19, R20). The licensee also failed to ensure cycle fill medications (medications supplied by pharmacy on scheduled basis) were securely locked from all residents, visitors, and families. 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: STORAGE OF MEDICATIONS R4 R4 was admitted for services on April 1, 2019, with diagnoses including disease of spinal cord, constipation, osteoarthritis, cerebral palsy, and chronic obstructive pulmonary disease (COPD). R4's Service Plan signed April 10, 2023, indicated R4 received services including assistance with exercises, bathing, bed mobility, behavior, dressing, grooming, transfers, medication administration, toileting, and safety checks. R4's Service Plan signed April 10, 2023, indicated R4 received medication management and all medications will be stored in a locked medication cart. The service plan also indicated medications would be stored according to the facility's medication storage practices or individual resident needs/preferences. R4's AL Nursing Assessment dated May 19, 2023, indicated R4 did not have preferences in	01880		

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01880	Continued From page 63 how to take his medications. On July 25, 2023, at 9:40 a.m., the surveyor observed unlicensed personnel (ULP)-C set up R4's medications. ULP-C set up one oyster calcium/ vitamin D 500 milligram (mg)-200 unit (u) caplet, one tab-a-vite multivitamin tablet, and one tamsulosin 0.4 mg capsule in a second paper medication cup then placed another paper cup on top of the three medications to cover them. ULP-C stated R4 would not take the three medications until he was at the dining room table. ULP-C proceeded to enter R4's room and administered his other scheduled oral medications and inhaler. ULP-C placed the second medication cup with the three medications on R4's desk while ULP-C and ULP-E assisted R4 to the bathroom. ULP-C then left the room to document the medication administration and set up R24's medications and administered those. At 10:34 a.m., ULP-C set up and administered R12's as needed (PRN) pain medication. ULP-C then set up R4's place at the dining room table with two cups of prune juice, plate, silverware and the remaining three medications. ULP-C walked away from the table and left them there while R4 was still in his room. Surveyor did not see any other residents nearby upon exiting the area. During interview on July 25, 2023, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated it was expected staff stay with the resident until all medications were administered when receiving medication management services. CNS-A was aware R4 liked to take his three medications with his meal, but stated it was not okay to leave the medications unattended. CNS-A also stated R4 can get angry and yell at staff for not having the medications at the table ready, but CNS-A stated,	01880		

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01880	Continued From page 64 "if he cussed you off, that's okay." R19 R19 admitted to licensee on May 15, 2019, and had diagnoses including type II diabetes with diabetic neuropathy, Parkinson's disease, and bipolar disorder. R19's Service Plan signed April 13, 2023, indicated R19 received medication administration, oxygen therapy, insulin administration, and blood glucose monitoring. R19's AL Nursing Assessment dated May 8, 2023, assessed R19 needed asssistance with medication and treatment administration including insulin administration and blood glucose checks. On July 26, 2023, at 9:35 a.m., the surveyor observed an unsecured metal box approximate size three inch by twelve inch containing diabetic testing supplies (glucometer, lancets, needles) with Lantus and Humalog Kwik pens sitting on R19's recliner. R19's Medication Administration Record (MAR) dated July 1, 2023, through July 25, 2023, indicated staff administered Humalog and Lantus insulin daily. During interview on July 26, 2023, at 9:35 a.m., R19 stated, "I'm not sure why it is in the room, I didn't request they be in the room." R19 also stated, "It really should be put up, I'm surprised they laid it out." R20 R20 was admitted to licensee on June 30, 2018, and had diagnoses including diabetes mellitus, paranoia type schizophrenia, and shortness of	01880		

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01880	Continued From page 65 breath. On July 26, 2023, at 10:00 a.m., the surveyor observed an unsecured metal box approximate size three inch by twelve inch containing diabetic testing supplies with NovoLog and Tresiba flex pens sitting on R20's table next to the opening of the room left wide open. R20's AL Nursing Assessment dated June 20, 2023, assessed R20 required assistance with medication administration. R20's MAR dated July 1, 2023, through July 25, 2023, indicated staff had administered both Tresiba and NovoLog insulin daily. During interview on July 26, 2023, at 10:00 a.m., the surveyor asked R20 if she self-administered the insulin and R20 stated, "most of the time staff will administer it." R20 stated the licensee managed her oral medications. CYCLE MEDICATIONS On July 25, 2023, at 8:25 a.m., while ULP-E was setting up medications for a resident, the surveyor observed large cardboard boxes under a desk out in the open next to the dining room in building one. Each cardboard box had a label from the pharmacy and the opening of both ends were closed with an orange zip tie. On July 25, 2023, at 11:55 a.m., the surveyor observed the same cardboard boxes under the desk of building one. On July 25, 2023, at 12:36 p.m., surveyors observed the same carboard boxes under the desk of building one.	01880		

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01880	Continued From page 66 During interview on July 25, 1:00 p.m., CNS-A stated cycle medications should not have been under the desk, but stored in the staff break room which was two rooms behind the desk. Surveyor asked if the staff break room locked, and CNS-A stated it did not have locking capabilities. CNS-A was not aware the medications were already delivered. During interview on July 27, 2023, at 1:41 p.m., CNS-A stated the metal medication boxes were supposed to be locked in resident rooms so staff could check the blood sugars and administer insulin in private. CNS-A stated they thought there were locks on those boxes and the medication passer had a key to open all boxes. MEDICATION CART On July 25, 2023, at 11:55 a.m., the surveyor observed the medication cart for house one in a common area by the front door and dining room, unattended and unlocked with keys on top of the cart. There were no employees visible in the entire area. At 12:04 p.m., the surveyor observed ULP- E walk into the area from the other part of the building. ULP-E stated they were passing medications and must not have locked the cart or taken their keys with them. On July 25, 2023, at 12:40 p.m., CNS-A stated the medication carts should never be left unlocked and employees should keep keys secure at all times. The licensee's Storage of Medication policy dated August 1, 2021, indicated the RN would establish a system that addresses the storage and handling of medications, including; -how medications would be received and secured when delivered by the pharmacy;	01880		

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01880	Continued From page 67 -where medications would be stored; -how medications would be secured if in the client's private living space or if centrally stored; -who is authorized to access the medications; -how refills and prescription renewals would be monitored; and -controls and procedures to identify or prevent diversion of medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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 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 maintained to include the opened-on date for time sensitive medication storage for six of ten residents (R11, R12, R14, R15, R19, R20), and bearing the original prescription label with legible information for one of ten residents (R12). In addition, the licensee failed to dispose of expired medications on two of two medication carts in house two. This had the potential to affect all the residents in house two. This practice resulted in a level two violation (a	01890		

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01890	Continued From page 68 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: TIME SENSITIVE MEDICATIONS R11 R11 admitted to licensee on October 17, 2023, and had diagnoses including type II diabetes with diabetic chronic kidney disease, diabetic neuropathy, morbid obesity, and high cholesterol. R11's prescriber orders dated May 11, 2023, ordered: -Humalog insulin, inject 15 u three times a day with meals for diabetes. On July 25, 2023, at 8:49 a.m., the surveyor observed unlicensed personnel (ULP)-C administer Humalog insulin Flex pen 15 units (u) subcutaneously (SQ) in R11's right bicep. The Humalog Flex pen did not bear an opened-on date. R12 R12 admitted to licensee on November 12, 2019, and had diagnoses including type II diabetes with diabetic polyneuropathy, chronic kidney disease, and chronic pulmonary obstructive disease (COPD). R12's prescriber orders dated June 28, 2023, ordered Incruse Ellipta 62.5 mg, 1 puff by mouth daily for COPD and insulin aspart flex pen, inject	01890		

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THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

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01890	Continued From page 69 6 u SQ three times a day with meals for diabetes. R12's prescriber orders dated July 7, 2023, indicated to discontinue previous orders for Basaglar and start Basaglar 28 u SQ twice a day for DM. On July 25, 2023, at 9:11 a.m., surveyor observed ULP-C administer the following: -Incruse Ellipta 62.5 mg, 1 puff by mouth daily for COPD. The Incruse Ellipta had a label to record an opened-on date and indicated the following, "discard 6 weeks after opening." No opened-on date was recorded; -insulin aspart flex pen, inject 6 u SQ three times a day with meals. The insulin aspart flex pen had no label to record the opened-on date; and -Basaglar Kwikpen 100 u/mL insulin, inject 25 u (incorrect dose) SQ twice a day. The Basaglar Kwikpen had no label to record the opened-on date. R14 R14 admitted to licensee on June 10, 2015, and had diagnoses including type II diabetes and COPD. R14's prescriber orders dated May 23, 2023, ordered insulin aspart flex pen, inject 15 u SQ three times a day with meals for diabetes. On July 25, 2023, at 7:48 a.m., the surveyor observed an unsecured metal box approximate size three inch by twelve inch in R14's room. The box contained diabetic testing supplies (glucometer, lancets, needles, alcohol prep pads). The box also contained R14's Lantus and two open Humalog insulin pens that did not bear an opened-on date.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20315	A. BUILDING: _____ B. WING _____	07/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

(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
01890	Continued From page 70 On July 25, 2023, at 7:48 a.m., the surveyor observed ULP-B administer the following: -Humalog pen 100 u/ml, injected 15 u SQ. R15 R15 admitted to licensee on September 17, 2019, and had diagnoses including moderate unspecified intracranial injury and major depressive disorder. On July 25, 2023, at 8:02 a.m., the surveyor observed ULP-B administer the following to R15: -Symbicort 80 mcg per ACT Inhaler- 2 puffs by mouth. The Symbicort inhaler did not have an opened-on date noted on the inhaler or the box it came in. R19 R19 admitted to licensee on May 15, 2019, and had diagnoses including type II diabetes with diabetic neuropathy, Parkinson's disease, and bipolar disorder. R19's Service Plan signed April 13, 2023, indicated R19 received medication administration, oxygen therapy, insulin administration, and blood glucose monitoring. R19's AL Nursing Assessment dated May 8, 2023, assessed R19 needed asssistance with medication and treatment administration including insulin administration and blood glucose checks. On July 26, 2023, at 9:35 a.m., the surveyor observed an unsecured metal box approximate size three inch by twelve inch containing diabetic testing supplies (glucometer, lancets, needles) with opened Lantus and Humalog Kwik pens that did not bear an opened-on date.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20315	A. BUILDING: _____ B. WING _____	07/28/2023

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THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

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01890	Continued From page 71 R20 R20 was admitted to licensee on June 30, 2018, and had diagnoses including diabetes mellitus, paranoia type schizophrenia, and shortness of breath. R20's AL Nursing Assessment dated June 20, 2023, assessed R20 required assistance with medication administration. On July 26, 2023, at 10:00 a.m., surveyor observed an unsecured metal box approximate size three inch by twelve inch containing diabetic testing supplies (glucometer, lancets, needles) with NovoLog flex pen, opened-on date of July 23, 2023, and opened Tresiba Flex pen which did not bear an opened-on date. On July 25, 2023, at 8:10 a.m., ULP-B stated they were trained to put the date on any medication they open. ULP-B stated they recognized there was not a date on several of the medications they had administered. ULP-B stated, "If I were the one opening them first, I would date them. I can't fix them now because I don't know when it was opened". ULP-B did not know of any additional measures they should take related to the undated medication labels. During interview on July 25, at 8:49 a.m., surveyor asked ULP-C the requirements for labeling insulin pens. ULP-C stated they should be labeled with an opened date (she showed surveyor one she had labeled). ULP-C stated she did not open the insulin pen that wasn't labeled. During interview on July 25, 2023, at 11:30 a.m., ULP-C stated she had not been trained to label open dates on inhalers.	01890		

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	20315	A. BUILDING: _____ B. WING _____	07/28/2023

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THE PRAIRIE LODGE AT EARLE BRO	6001 EARLE BROWN DRIVE BROOKLYN CENTER, MN 55430

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01890	Continued From page 72 During interview on July 25, 2023, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated insulin should have an open date labeled on the pen. Staff are to use the open labels provided by the pharmacy. If the open labels are not available, they would get more from the pharmacy. CNS-A stated for inhalers, staff should date and initial when they were opened. CNS-A also stated she provided staff training February 2023 on insulin administration and blood glucose checks. Humalog FlexPen manufacturer instructions dated as revised July 2023, directed the medication should be discarded 28 days after opened even if insulin is left. Lantus FlexPen manufacturer instructions dated as revised August 2022, directed the medication should be discarded 28 days after opened even if insulin is left. Novolog FlexPen (insulin aspart) manufacturer instructions dated as revised February 2023, directed the medication should be discarded 28 days after opened. Basaglar KwikPen manufacturer instructions dated as revised November 2022, directed the medication should be discarded 28 days after opened. Tresiba manufacturer instructions dated as revised July 2022, directed the medication should be discarded 56 days after opened. Incruse Ellipta manufacturer instructions dated as revised June 2019, directed the medication should be discarded six weeks after opened. Brea Ellipta manufacturer instructions dated as	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20315	A. BUILDING: _____ B. WING _____	07/28/2023

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01890	Continued From page 73 revised May, 2023, directed the medication should be discarded six weeks after opened. Symbicort manufacturer instructions dated as revised 2010, directed the medication should be discarded three months after opened. NO PRESCRIPTION LABEL R12 R12's prescriber orders dated June 28, 2023, ordered lidocaine 2% jelly, 5 ml topically to tip of penis every eight hours scheduled for discomfort. On July 25, 2023, at 9:11 a.m., the surveyor observed ULP-C remove from the central medication cart a lidocaine 2% jelly tube without a prescription label and no resident identification present and administered a large drop to the tip of R12's penis. EXPIRED MEDICATION On July 25, 2023, at 10:39 a.m., the surveyor observed a medication cart in unsecured unit of house two and observed the following expired medications: - R5 medication card of stool softener with lax tablets with an expiration date of June 17, 2023. - R5 medication card of hyoscyamine 0.125 mg sl tablets with an expiration date of May 16, 2023. - R5 medication card of lorazepam solutabs 0.5 mg with an expiration date of July 11, 2023. - R15 medication card of ibuprofen 800 mg tablets with an expiration date of June 7, 2023. - R9 medication card of trazodone 50 mg tablets with an expiration date of July 7, 2023. - R9 box of nicotine 21 mg/ 24 hour patches with an expiration date of April, 2023. - R9 box of nicotine 21 mg/ 24 hour patches with an expiration date of February, 2023. - R8 medication card of docusate sodium senna	01890		

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01890	Continued From page 74 50 mg/ 8.6 mg with an expiration date of April, 23, 2023. On July 25, 2023, at 9:50 a.m., the surveyor observed a medication cart in the secured unit of house two and observed a bottle of senna 8.6 milligram (mg) tablets unlabeled and expired July 21, 2023. On July 25, 2023, at 10:20 a.m., ULP-I stated it was the RN's responsibility to audit the medication cart to remove expired medications. ULP-I also stated if they see an expired medication, they will call the RN to inform them. On July 25, 2023, at 10:30 a.m., CNS-A stated the medication carts are audited weekly to remove expired medications. CNS-A also stated for that week they had not audited the medication carts. The licensee's Storage of Medications policy dated August 1, 2021, indicated the registered nurse (RN) must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the [resident's] medications and whether secured storage is appropriate given the resident's functional and cognitive status, concerns about the potential for drug diversion and other considerations. Based on this assessment, the RN would develop an individualized medication management plan for the resident that would address storage of the resident's medications. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R4) who received a treatment. 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 was admitted for services on April 1, 2019, with diagnoses including disease of spinal cord, constipation, osteoarthritis, cerebral palsy, and chronic obstructive pulmonary disease (COPD). R4's Service Plan signed April 10, 2023, indicated R4 received services including assistance with exercises, bathing, bed mobility, behavior,	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20315	A. BUILDING: _____ B. WING _____	07/28/2023

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01970	Continued From page 76 dressing, compression stockings, grooming, transfers, medication administration, toileting, and safety checks. R4's AL Nursing Assessment dated May 19, 2023, assessed R4 needed assistance of one to pull on and remove TED hose/compression stockings and washing them. R4's record lacked a current order for the application of compression stockings. On July 27, 2023, at 3:22 p.m., surveyor requested the prescribers' order for R4's compression stockings. Clinical nurse supervisor (CNS)-A stated she had an order available for R4's compression stockings, but it was dated 2019. CNS-A stated she did not have a current order available. CNS-A stated it should have been updated annually. The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders policy dated August 1, 2021, indicated an order for a treatment or therapy must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. The RN will ensure that the prescriber renews a treatment or therapy order at least every 12 months or more frequently if determined necessary based on the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02350	Continued From page 77	02350		
02350 SS=F	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a resident's property was treated with courtesy and respect when staff used a resident's blood glucose machine (R7) to check blood sugar readings for another resident (R9) observed during medication pass. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 25, 2023, at 10:32 a.m., the surveyor observed unlicensed personnel (ULP)-B attempt to check R9's blood glucose level. R9 insisted on sticking his own finger with the lancet and did not have good blood return. R9 refused to let ULP-B touch his finger while attempting to check R9's blood glucose level. ULP-B got an error message on their first attempt to check R9's blood glucose level with R9's machine. ULP-B removed another resident's (R7) blood glucose machine from the medication cart, and attempted to check R9's blood glucose level. R7's machine also resulted	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02350	Continued From page 78 with an error message when ULP-B inserted the strip with R9's blood on it. ULP-B removed another blood glucose machine from the cart, however, R9 shouted, "that's it, you're done", and walked away from the medication cart. ULP-B returned the blood glucose machines to their cases without cleaning and return the cases to the medication cart. On July 25, 2023, at 10:39 a.m., when asked about cleaning of blood glucose machines, ULP-B reported staff will use another resident's blood glucose machine when someone's machine is not working right. When asked about cleaning the blood glucose machine, ULP-B stated they are cleaned when visibly soiled. On July 25, 2023, at 12:40 p.m., CNS-A stated each medication cart should have a spare blood glucose machine to use in the case of anyone's personal machine malfunctioning. If there is not a spare blood glucose machine on one of the medication carts CNS-A stated, the ULP should check the other medication cart in the building they are working in. CNS-A stated the ULP should use alcohol or sanitizing wipe to clean all blood glucose machines after use. The licensee's blood glucose competency document presented as staff education on February 16, 2023, by CNS-A lacked direction on cleaning the blood glucose machine or identification of a resident's own equipment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02350		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64975
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *07/24/23*
Time: 12:35:20
Report: 8058231156

Food and Beverage Establishment Inspection Report

Location:
The Prairie Lodge At Earle Bro
6001 Earle Brown Drive
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0037751
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635661495
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11C

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

CLEAN INTERIOR OF DINING ROOM COOLER (BUILDING 1)

Comply By: 07/25/23

8-500A Embargo/Condemnation

8-501.03MN

MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:

ITEMS IN DINING ROOM COOLER (BUILDING 2) - SEE NOTES

Comply By: 07/24/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at --- Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Hot Water: = --- at 193 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *07/24/23*
Time: 12:35:20
Report: 8058231156
The Prairie Lodge At Earle Bro

Food and Beverage Establishment Inspection Report

Process/Item: YOGURT
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: STRAWBERRY
Temperature: 39 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: BURGER
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD FACILITY INSPECTION

-COMMERCIAL FACILITY, 3 BUILDING EACH WITH KITCHEN. ONLY TWO BUILDING ARE IN USE AND OCCUPIED

BUILDING 2 DINING AREA LOST POWER AFTER A SPRINKLER RELEASE TOOK PLACE. POWER WAS LOST LONG ENOUGH FOR THE FOOD TEMPERATURES IN THE COOLER TO RAISE ABOVE 41 DF FOR AN EXTENDED AMOUNT OF TIME.

DISCUSSED LIMITED ACCESS TO FOOD STAFF ONLY IN KITCHENS AND KITCHEN STAFF MANAGING THE USE OF DINING ROOM KITCHENS

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 8058231156 of 07/24/23.

Certified Food Protection Manager BENJAMIN HENRY HANSON

Certification Number: 107677 Expires: 09/19/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
BEN HENRY HANSON
PIC

Signed: _____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us