



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 31, 2025

Licensee

Americare Lodges Inc.

6870 Schultz Drive Northeast

Remer, MN 56672

RE: Project Number(s) SL30705016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 5, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

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

0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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To submit a hearing request, please visit:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30705	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER AMERICARE LODGES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 6870 SCHULTZ DRIVE NE REMER, MN 56672			
(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 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: SL30705016 On December 3, 2024, through December 5, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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

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0 470	Continued From page 2 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: The licensee held an assisted living facility license. The facility was licensed for ten residents and had a current census of five residents. On December 4, 2024, at 10:31 a.m., during the entrance conference, with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C, CNS-C stated the facility's staffing plan was reviewed recently but she could not remember the exact date. LALD-A stated the daily staff schedule was: -two unlicensed personnel (ULP) worked from 6:00 a.m. until 2:00 p.m. -two ULP worked from 2:00 p.m. until 10:00 p.m. -one ULP worked from 10:00 p.m. until 6:00 a.m. On December 3, 2024, at 12:12 p.m., the surveyor reviewed the facility's staffing plans with CNS-C, dated as follows: -September 13, 2022 -August 4, 2023 -September 4, 2024. Directly after this review CNS-C stated staffing plans were reviewed yearly. On December 3, 2024, at approximately 12:15 p.m., the surveyor reviewed the facility staffing plan dated September 13, 2024, which noted: - "The purpose of the Contingency Staffing Plan	0 470			

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0 470	Continued From page 3 was to coordinate strategies to ensure continuity of operations. The plan takes an all- hazard approach that addresses natural, manmade, and technological hazards Resident need Focused: -How are resident's needs identified? Through assessments upon admission, every 90 days and with any change of condition -How is resident acuity identified based on assessments? Upon RN assessment, updates are made to care plan and service plans as changes occur -Can the resident's scheduled and reasonable foreseeable unscheduled needs be met given the physical layout of the facility? yes -Does staffing change based on staff experience, training, and competency? yes, training shifts include extra staff. All staff are competently signed off with nursing upon hire and yearly." The facility's staffing plan lacked evidence of being reviewed at least twice a year and no metric was used to determine staffing needs. On December 3, 2024, at 12:20 p.m., CNS-C stated she did not know that staffing plans were to be reviewed at least twice a year. CNS-C said she did not know a metric was needed to determine staffing levels. CNS-C added the use of a metric to determine staffing needs made sense. The licensee's Staffing & Scheduling policy dated November 21, 2023, noted, the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24 hours a day, seven-days a week. The clinical nurse supervisor must ensure that staffing levels were adequate to address the	0 470			

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0 470	Continued From page 4 following: -each resident's needs, as identified in the resident's service plan and assisted living contract -each resident' acuity level, as determined by the most recent assessment or individualized review -the ability of staff to timely meet the resident' scheduled and reasonable foreseeable unscheduled needs given the physical layout of the facility premises -whether the facility had a secured dementia care unit, and -staff experience, training, and competency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed	0 480			

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0 480	Continued From page 5 unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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	0 480			

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0 480	Continued From page 6 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 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.	0 510			

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0 510	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure infection control standards were followed for one of one employee, (licensed practical nurse (LPN)-D) with shared equipment. In addition, the licensee failed to ensure infection control standards were followed by one of two unlicensed personnel (ULP)-B while providing assistance to 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: SHARED EQUIPMENT On December 4, 2024, at 7:47 a.m., the surveyor observed LPN-D remove a SpO2 monitor (device used to monitor blood oxygenation percentage and pulse) which hung on a wall in the medication room. LPN-D took the SpO2 monitor to the kitchen table and placed the monitor on R4's finger. The surveyor did not observe LPN-D sanitize the SpO2 monitor prior to use. A reading of 94% was obtained. LPN-D removed the SpO2 monitor from R4's finger and returned the monitor to the medication room and hung the SpO2 monitor up on the wall. The surveyor did not observe LPN-D sanitize the SpO2 monitor after use.	0 510			

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0 510	Continued From page 8 On December 4, 2024, at 8:00 a.m. LPN-D stated "the truth is" equipment should be cleaned after every use. LPN-D added everything should be cleaned. LPN-D said she did not clean the SpO2 monitor as required. On December 4, 2024, at 10:42 a.m., clinical nurse supervisor (CNS)-C stated shared equipment should be cleaned after every use. The licensee's undated (name of facility) Infection Prevention and Control Manual noted whenever possible, dedicated equipment was to be used only on that resident. In the event that equipment must be shared it (equipment) required thorough cleaning and disinfection in between residents. RESIDENT ASSISTANCE On December 4, 2024, at 7:04 a.m., the surveyor observed ULP-B wearing gloves lower R4's brief and assist R4 onto the toilet. ULP-B removed R4's pajamas, and R4's wet brief. ULP-B removed the gloves worn. The surveyor did not observe ULP-B perform hand hygiene. ULP-B applied a new pair of gloves. ULP-B moistened a washcloth and washed R4's face. ULP-B rinsed the washcloth and cleaned R4's legs and dried R4's legs. ULP-B picked up a medication cup that LPN-D had placed on the top of the toilet tank which contained Biofreeze (pain relief cream) and applied the Biofreeze to R4's left knee and rubbed the cream in. ULP-B applied Biofreeze to R4's right knee and rubbed the Biofreeze cream in. ULP-B removed gloves. The surveyor did not observe ULP-B perform hand hygiene prior to or after medication administration. ULP-B applied gloves and dressed R4 in a clean brief, socks, and pants. ULP-B used a washcloth and cleaned under R4's breasts. ULP-B dressed R4 in a shirt	0 510			

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0 510	Continued From page 9 and removed gloves. The surveyor did not observe ULP-B perform hand hygiene. On December 4, 2024, at 7:24 a.m., ULP-B applied clean gloves. ULP-B removed R4's top denture plate from R4's mouth. ULP-B held R4's denture in gloved hand and brushed the plate with toothpaste and rinsed the plate. ULP-B returned R4's top denture plate to R4's mouth. ULP-B removed gloves. The surveyor did not observe ULP-B perform hand hygiene. On December 4, 2024, at 7:27 a.m., ULP-B removed a hair tie, and braid from R4's hair. ULP-B brushed R4's hair and re-braided R4's hair. On December 4, 2024, at 7:32 a.m., the surveyor observed ULP-B apply gloves. The surveyor did not observe ULP-B perform hand hygiene. ULP-B washed R4's peri area, and pull up R4's clean brief, and pants. ULP-B removed gloves. The surveyor did not observe ULP-B perform hand hygiene. ULP-B dressed R4 with gripper socks and a vest. On December 4, 2024, at 7:33 a.m., the surveyor observed ULP-B apply gloves. The surveyor did not observe ULP-B perform hand hygiene. ULP-B applied Biofreeze to the back of R4's neck. ULP-B removed the right glove worn. ULP-B reapplied a right glove. The surveyor did not observe ULP-B perform hand hygiene. On December 4, 2024, at 7:37 a.m., ULP-B assisted R4 to the dining area. ULP-B held a trash bag and a laundry bag in gloved hand. ULP-B unlocked the laundry room door and left the laundry there. ULP-B took the trash bag to the kitchen and placed the trash bag outside. ULP-B	0 510			

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0 510	Continued From page 10 removed the glove and washed her hands. On December 4, 2024, at 7:42 a.m., ULP-B stated she "never paid attention" about glove changing and hand hygiene. The surveyor asked ULP-B if hands should be sanitized in-between gloves, and gloves changed in-between cares/ clean to dirty, and medication administration? ULP-B said, yes. On December 4, 2024, at 8:02 a.m., ULP-B stated she did not normally wash her hands or use hand sanitizer when she changed gloves. On December 4, 2024, at 10:43 a.m., CNS-C stated staff should wash hands or use sanitizer in-between glove use, that was CNS-C's expectation. The licensee's undated Learning and Disinfecting Your Facility information sheet found in the facility's policy binder noted always wash immediately after removing gloves and after contact with a person who is sick. When laundering clothing, towels, linens and other items, remove gloves, and wash hands right away. The licensee's Infection Control Guidelines for all Procedures policy dated November 12, 2020, noted employees must wash their hands for twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: -before and after direct contact with residents, and after removing gloves. The licensee's Denture Care policy dated November 6, 2023, noted: -gather needed equipment	0 510			

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0 510	Continued From page 11 -explain procedure and provide privacy to resident -wash hands and apply gloves -remove dentures and place in a basin, protecting them from breakage -brush and rinse dentures carefully using toothbrush, toothpaste and running water, "cup" dentures in your gloved hand -place clean dentures into denture cup with water -allow resident to brush and rinse moth and tongue, as can -check mouth for sores or redness -assist resident to replace dentures. If dentures are stored, leave them covered in water -remove gloves and wash hands. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced	0 640			

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0 640	Continued From page 12 by: Based on observation and interview, the licensee failed to post the required content in common area to include posting the 911 emergency number in common areas and near one of two telephones (kitchen) provided by the assisted living facility. This had the potential to affect five residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 3, 2024, at approximately 10:30 a.m., during a tour of the facility with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C, the surveyor did not see 911 posted in the common's area. The surveyor asked if there was a telephone residents could use. Licensed practical nurse (LPN)-D stated there was a phone (cordless) in the kitchen residents could use. The surveyor did not see 911 posted on or near the kitchen telephone. LPN-D stated someone covered it up, there was a yellow sticker on the phone. The surveyor was told there was one other phone (cordless) residents could use, in the locked medication room. The surveyor observed 911 posted on the medication room phone. On December 3, 2024, at 10:38 a.m., LALD-A stated 911 was not posted in the common's area	0 640			

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0 640	Continued From page 13 as required. LALD-A confirmed the telephone in the kitchen/ common's area did not include 911 on or near the telephone. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated November 21, 2023, noted (name of facility) would post information for reporting suspected crime and maltreatment. The facility would support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: -posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, 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;	0 650			

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0 650	Continued From page 14 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required content for two of three employees, (clinical nurse supervisor (CNS)-C, licensed practical nurse (LPN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CNS-C CNS-C was hired on November 16, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On December 3, 2024, at 10:00 a.m., during the entrance conference, CNS-C identified herself as the CNS for the facility.	0 650			

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0 650	Continued From page 15 CNS-C's employee record did not include two hours of annual dementia training, the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person and a review of infection control techniques. On December 4, 2024, at 1:18 p.m., LALD-A stated all nurse's complete the same orientation at the time of hire and annually. LALD-A stated Educare (on-line learning system) had been used. LALD-A added the paperwork "might not be here." (in CNS-C's record) On December 4, 2024, at 1:28 p.m., LALD-A stated licensee did not have CNS-C's complete annual training record. LALD-A added licensee got in a "big fight" with Educare and the licensee got cut off that day from Educare, without access to records. On December 4, 2024, at 6:58 p.m., the surveyor received an email from LALD-A that noted: -"I called Educare (on-line system) to request transcripts. The lady from Educare was less than accommodating and will not send us the transcripts from the times we paid for their services without signing a year contract with them for \$2100." LALD-A noted the licensee did not have CNS-C's annual training record as required. On December 5, 2024, at approximately 2:45 p.m., LALD-A and CNS-C stated other employee's records would lack required training requirements. LPN-D LPN-D was hired on April 18, 2021, to provide direct care and services to the licensee's residents and oversight of the licensee's	0 650			

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0 650	Continued From page 16 employees. On December 4, 2024, at 11:15 a.m., the surveyor observed LPN-D take R3's blood glucose level with correct technique. On December 5, 2024, at approximately 2:45 p.m. LALD-D stated she had LPN-D's 2022-, and 2023-year reviews. LALD-A stated LPN-D's 2024 performance review may be at the other site (affiliated) as "they" shared LPN-D. LALD-A stated LPN-D's annual 2024 performance review was not in LPN-D's record. The surveyor asked LALD-A to send LPN-D's 2022, and 2023 performance reviews, however the surveyor did not receive LPN-D's past performance reviews. LPN-D's employee record did not include an annual performance review as required. The licensee's Employee Records policy dated November 21, 2023, noted employee records for each person would include: -records of all training and in-service education required and/or provided including record of competency testing as required -current signed job description, which included qualifications, responsibilities, and identification of supervisors, if any -documentation of annual performance reviews that identify areas of improvement needed and training needs. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and	0 650			

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0 650	Continued From page 17 orientation topic: (1) facility name, location, and license number (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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;	0 680			

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0 680	Continued From page 18 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 3, 2024, at 10:31 a.m., during the entrance conference licensed assisted living director (LALD)-A, it was stated the EPP binder	0 680			

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0 680	Continued From page 19 was in the staff office (on-site), and we (licensee) have a copy in the main office (off site) as well. LALD-A added she pulled the EPP binder into the office for the surveyor. On December 3, 2024, at 10:41 a.m., during a tour of the facility with LALD-A, LALD-A stated the EPP binder(s) was normally "locked up". LALD-A said there was no signage posted as to the EPP's location. On December 3, 2024, at 11:16 a.m., LALD-A asked if the facility's EPP could be reviewed "tomorrow" as the binder was not currently on site (at facility). The licensee's EPP, dated April 16, 2024, did not include the following: - a quarterly review of the missing resident policy - a description of the population served by the licensee. On December 4, 2024, at 9:47 a.m., the facilities EPP was reviewed with LALD-A. LALD-A stated she did not know that the missing person policy required review quarterly. In addition, LALD-A stated "they" (licensee's staff) talked about not having a description of the population served by the licensee "yesterday," in the EPP. Later in the conversation LALD-A stated there was a description of the population in the facility's "fire" binder. LALD-A stated she was aware the EPP should be accessible at all times. The licensee's Missing Resident policy date November 21, 2023, noted the (name of facility) would review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes would be documented.	0 680			

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0 680	Continued From page 20 The licensee's Disaster Planning and Emergency Preparedness policy dated November 21, 2023, noted (name of facility) would have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS (Centers for Medicare & Medicaid Services) Appendix Z. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for	0 780			

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0 780	Continued From page 21 sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include:	0 780			

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0 780	Continued From page 22 On a facility tour on December 4, 2024, from 10:30 a.m. to 11:45 a.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC): CARBON MONOXIDE ALARMS The surveyor observed there were no carbon monoxide alarms installed in the facility. The surveyor explained to LALD-A, carbon monoxide alarms are required to be installed outside and within ten feet of all resident sleeping rooms in accordance with MSFC Section 1103. DOOR LOCKING There were chain security locks installed on the outside (non-egress side) of several doors throughout the facility including the storage room door near the kitchen, office/ resident room two, shower room, and laundry room. The surveyor explained to LALD-A, all rooms and spaces are required to be provided with an exit access door that opens to egress from the inside without the use of keys tools or special knowledge in accordance with MSFC Chapter 11 and Section 1010. SMOKE ALARM MAINTENANCE The smoke alarm in the hallway near resident room six was removed and found to have a manufacture date of October 2011. The surveyor explained to LALD-A, all smoke alarms are required to be replaced when they	0 780			

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0 780	Continued From page 23 exceed ten years from date of manufacture in accordance with MNFC Section 1103 and manufactures installation instructions. ELECTRICAL COVERS The electrical light fixture was missing the fixture cover on the ceiling in the office/ resident room two. The surveyor explained to LALD-A, electrical fixture and outlet covers are required to be maintained in place in accordance with MSFC Section 604. During the facility tour LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical	0 800			

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0 800	Continued From page 24 environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on December 4, 2024, from 10:30 a.m. to 11:45 a.m., with licensed assisted living director (LALD)-A, the surveyor made the following observations of facility disrepair: The air exchange unit in the boiler room was not operating, and the intake vent on the exterior was plugged with dirt preventing fresh air to enter as designed. The shower room and other rooms were not provided with ventilation air as designed because the air exchanger was not running. The surveyor explained to LALD-A, the air exchanger is required to be maintained as designed and in operation in order to maintain indoor air quality for the facility. During a facility tour on LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			

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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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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 observation, interview and record review, provide required training and drills and.	0 810			

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0 810	Continued From page 26 This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 4, 2024, at 10:00 a.m., licensed assisted living director (LALD)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The location and number of resident sleeping rooms were identified on the floor plan but the room identified as resident room two was used as an office. The numbers on the doors matching the numbers on the FSEP evacuation floor plan were installed but covered with decorations and were not readily visible. The surveyor explained to LALD-A, that resident sleeping room numbers on the evacuation floor plan are required to match the numbers on the doors and be visible on the doors in order to direct building occupants to an exit in the event of a fire or similar emergency.	0 810			

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0 810	Continued From page 27 During an interview on December 4, 2024, at 10:10 a.m., LALD-A, verified the room numbers on the doors were covered and the FSEP evacuation floor plan was not accurate to the use of resident room two. During the same interview LALD-A, stated they will revise the FSEP evacuation floor plan and install larger numbers on the side of the door frame instead of on the door so they will be visible. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP at least twice per year as evident by not providing documentation the training was completed as required. During an interview on December 4, 2024, at 10:20 a.m., LALD-A, stated documentation was not available for training of employees twice per year after hire. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed in January, March, May, and September only in 2024. No other drill documentation was provided for 2024. During an interview on December 4, 2024, at 10:25 a.m., LALD-A, stated documentation was not available for drills competed every other	0 810			

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0 810	Continued From page 28 month and twice per year per shift for the past year as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2's (name of licensee/facility) Resident Lease	0 970			

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0 970	Continued From page 29 and Services Agreement (contract) dated February 10, 2022, included, on page two of 24: Loss or Damage to Property: -This facility shall not be responsible for any loss or damage to any valuables, personal effects or money brought into the facility by the resident or any visitors, including but not limited to dentures, hearing aids, prostheses, and eyeglasses, unless such damage or loss is caused by the willful misconduct or negligent conduct of the facility staff. R2's (name of licensee/facility) Related Addendums Signature Sheet dated February 10, 2022, included, on page seven of two [sic]: Safety and Security: -The facility is not responsible for any loss or damage to residents' personal property, including cash, jewelry, dentures, hearing aids, prostheses, and other valuables, unless the loss or damage is caused by the negligence of the facility. As a resident of (name of licensee/facility) you may choose to obtain personal property insurance for your belongings. The facility does criminal background checks on all employees before being hired. On December 3, 2024, at 11:59 a.m., the licensee's contract was reviewed with licensed assisted living director (LALD)-A. LALD-A stated the licensee had made a couple of tweaks on the contracts after surveys were completed. LALD-A stated the licensee's current contract included a waiver of liability. LALD-A confirmed all the contracts were the same at the facility. On December 4, 2024, at 2:14 p.m., LALD-A said she knew that a facility contract could not include a waiver of liability, adding she (LALD-A) learned that at a class she took.	0 970			

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0 970	Continued From page 30 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) prepared in writing specific instructions for each resident and documented those instructions for two of two residents (R3, R2) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	01750			

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01750	Continued From page 31 portion or all of the residents). The findings include: R3 R3's diagnosis included diabetes. R3's service plan dated November 6, 2024, included medication administration. On December 4, 2024, at 11:15 a.m. the surveyor observed licensed practical nurse (LPN)-D prepare R3's Humalog insulin for administration using proper technique. LPN-D administered the insulin from one Flexpen into R3's right abdomen site and the Flexpen with the remaining dosage into R3's right upper arm site. R3's prescriber order dated October 18, 2024, included: -insulin 70/30 Novolog mix (short acting) pen injection: inject 15 units under skin before the first meal of the day. Administer within 15 minutes before a meal: resuspend immediately prior to use. -insulin 70/30 Novolog mix pen injection: inject six units under the skin one time a day with supper. Administer within 15 minutes before a meal: resuspend immediately prior to use. R3's medication administration record (MAR) dated November 1, 2024, through November 30, 2024, included: - Novolog mix 70-30 Flexpen, inject 15 units SQ (subcutaneously/under skin) once daily before the first meal of day. Gently roll insulin in palm for 15-30 seconds. Contact a nurse if blood glucose is 100 or below or if resident is declining to eat - Novolog mix 70-30 inject six units SQ daily place in palm of hands and roll until equally	01750			

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01750	Continued From page 32 mixed. Contact a nurse if blood glucose is 100 or below or if resident is declining to eat. R3's Medication Recap by Resident- with notes included: November 1, 2024, through November 7, 2024, Novolog Mix 70-30 Flexpen was administered daily 9:00 a.m., notes included: Novolog Mix 70-30 Flexpen -November 1, 2024, 9:00 a.m., "just got up": 5:15 p.m., BG (blood glucose) 150. Six units after meal. -November 2, 2024, 9:00 a.m., 15 units given (verified by initials), 5:15 p.m. back of left arm, gave after done with his dinner -November 3, 2024, 5:15 p.m., done -November 4, 2024, 5:15 p.m., done -November 5, 2024, 9:00 a.m., "just got up" -November 6, 2024, 5:15 p.m., left arm -November 7, 2024, 5:15 p.m., right arm. 3 of 14 opportunities R3's insulin administration site was documented. Medication Recap by Resident notes include: -November 8, 2024, through November 14, 2024: 0 of 14 opportunities R3's insulin administration site was documented. -November 15, 2024, through November 21, 2024; 3 of 14 opportunities R3's insulin administration was documented 3 of 3 opportunities the same site was used. -November 22, 2024, through November 28, 2024, 1 of 14 opportunities R3's insulin administration was documented. Directly after the surveyor's December 4, 2024, 11:15 a.m. observation, the surveyor asked LPN-D how LPN-D knew where R3's insulin had last been administered. LPN-D replied, "that is a good question." LPN-D stated she charted the sites in "notes", but she was not sure if	01750			

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01750	Continued From page 33 "everyone" (other staff) documented R3's insulin inject sites. LPN-D stated she was not aware if others looked at the notes to see where insulin had been previously administered. LPN-D scrolled down in the computer system used and stated she was not able to find any other notes other than the notes she wrote regarding R3's insulin site administration. On December 4, 2024, at 12:18 p.m., clinical nurse supervisor (CNS)-C stated insulin injection sites required a note. CNS-C stated she was able to locate, only in one chart (insulin administration), where there was a place indicated to write a note in a resident's record. CNS-C confirmed the entry did not state what the note was to include. CNS-C stated R3's record did not include specific instructions as required, to include insulin inject site. The manufacturer's direction for Novolog Flexpen dated January 2019, noted rotate injections between injection spots. Do not inject into the same spot every time. R2 R2's diagnoses included multiple sclerosis (disease impacting the central nervous system, brain, and spinal cord), weakness, dementia associated with alcoholism, and cognitive impairment. R2's service plan dated November 27, 2024, indicated R2 received the following services: medication administration. On December 4, 2024, at 6:16 a.m., the surveyor observed LPN-D adjust R2's tubigrip stockings (compression).	01750			

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01750	Continued From page 34 R2's prescriber order dated November 26, 2024, included: polyethylene glycol 3350 (MiraLAX) powder, take 17 grams by mouth one time a day. Mix in eight ounces of water, juice, soda, coffee, or tea prior to administration. R2's MAR dated December 1, 2024, through December 3, 2024, included: -polyethylene glycol 3350 powder daily, mix one capful (17 grams) in liquid and take by mouth once daily (constipation). On December 4, 2024, at 10:52 a.m., the surveyor reviewed R2's MAR and prescriber's order with CNS-C. CNS-C stated R2's MAR should have included specific instructions. CNS-C questioned out loud, "who did that?" (entered R2's MiraLAX order without full instructions.) The licensee's Medication & Treatment-Administration & Delegation policy dated November 16, 2023, noted a RN (registered nurse) must specify, in writing, specific instructions for each resident and document those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
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	01760			

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01760	Continued From page 35 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 two employees, (unlicensed personnel (ULP)-B, licensed practical nurse (LPN)-D), followed registered nurse (RN) written instructions and steps of medication administration of a topical ointment for one of one resident, (R4). Further, the licensee failed to ensure medication was given as prescribed for one of two residents (R2). Additionally, the licensee failed to ensure medication orders were transcribed correctly for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: FOLLOWING WRITTEN INSTRUCTION	01760			

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01760	Continued From page 36 R4's diagnoses included frontal temporal neurocognitive disorder (type of dementia). R4's service plan dated November 6, 2024, indicated R4 received medication administration six times per day. R4's prescriber order dated December 2, 2024, included: -Biofreeze (menthol/ pain relief) 10% cream, apply thin layer topically to affected area, BID (twice daily) R4's medication administration record (MAR) dated December 1, 2024, through December 4, 2024, included: -Biofreeze (daily) apply small amount to right knee twice daily (rub it in). On December 4, 2024, at 7:04 a.m., the surveyor observed ULP-B pick up a medication cup that LPN-D had placed on the top of the toilet tank which contained Biofreeze and applied the Biofreeze to R4's left knee and rubbed the cream in. ULP-B applied Biofreeze to R4's right knee and rubbed the Biofreeze cream in. On December 4, 2024, at 7:33 a.m., the surveyor observed ULP-B apply Biofreeze to the back of R4's neck. On December 5, 2024, at 2:10 p.m., clinical nurse supervisor (CNS)-C stated R4's MAR should have been followed and Bio-freeze applied to R4's right knee only as noted on R4's MAR. FOLLOWING THE STEPS OF THE MEDICATION ADMINISTRATION PROCESS On December 4, 2024, at 7:04 a.m., the surveyor observed ULP-B assist R4 with personal cares.	01760			

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01760	Continued From page 37 LPN-D entered R4's room and stated, here is her (R4's) Biofreeze, as LPN-D placed a medication cup with the topical medication on the top of the toilet tank. On December 4, 2024, at 7:42 a.m., ULP-B stated it was the normal process for ULP to apply R4's Biofreeze ointment. ULP-B said, "I think" LPN-D documented R4's Biofreeze. On December 4, 2024, at 7:50 a.m., the surveyor asked LPN-D if she documented R4's Biofreeze administration. LPN-D replied yes, and she (LPN-D) could show the surveyor. On December 4, 2024, at 8:01 a.m., LPN-D stated, "I trust my girls", when they get R4 up in the morning it is just easier, adding ULPs know how to apply R4's Biofreeze. LPN-D said she documented R4's Biofreeze ointment as administered prior to its application. LPN-D confirmed she did not apply R4's Biofreeze. On December 4, 2024, at 10:43 a.m., CNS-C stated a medication error occurred when ULP-B applied R4's Biofreeze medication. CNS-C stated LPN-D should have applied R4's Biofreeze. CNS-C said, the person (staff) who was assigned to the medication cart was to administer all medication and document after medication was administered. MEDICATION GIVEN AS PRESCRIBED R2's diagnoses included multiple sclerosis (disease impacting the central nervous system, brain, and spinal cord), weakness, dementia associated with alcoholism, and cognitive impairment. R2's service plan dated November 27, 2024,	01760			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30705	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/05/2024
NAME OF PROVIDER OR SUPPLIER AMERICARE LODGES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 6870 SCHULTZ DRIVE NE REMER, MN 56672		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 38 indicated R2 received the following services: medication administration. On December 4, 2024, at 6:16 a.m., the surveyor observed LPN-D adjust R2's tubigrip stockings (compression). R2's prescriber order dated November 26, 2024, included: -omeprazole (Prilosec/stomach acid) 20 milligrams (mg), delayed-release capsule: take one capsule by mouth once daily 30 minutes prior to breakfast. R2's December 1, 2024, through December 3, 2024, MAR included: -omeprazole 20 mg, take one tablet 30 minutes prior to meal on empty stomach, 4:30 p.m. On December 5, 2024, at approximately 2:00 p.m., CNS-C stated R2 received the correct dosage of omeprazole, however R2 did not receive the medication as ordered, prior to breakfast. TRANSCRIPTION ERROR R2's prescriber order dated November 26, 2024, included: -melatonin (sleep) five mg tablets, take three tablets by mouth at bedtime. R2's December 1, 2024, through December 3, 2024, MAR included: -melatonin three mg: take three tablets by mouth at HS (hour of sleep) to equal a total of 15 mg. On December 5, 2024, at 2:08 p.m., CNS-C stated R2's melatonin MAR entry was incorrect and should have noted to give three five milligram tablets.	01760			

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01760	Continued From page 39 The licensee's Medication Management-Administration & Setup policy dated November 16, 2023, noted the nursing staff and unlicensed personnel trained to provide medication administration at (name of facility) would document any medication administration provided accurately in each resident record. A licensed nurse would correctly and accurately document any medication setup provided. The licensee's Medication Management-Administration & Setup policy dated November 16, 2023, noted medication administration would be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given and include the full signature and title of the person who provided the medication administration. The licensee's Medications & Treatment Orders policy dated November 16, 2023, noted the RN (registered nurse) was responsible for assuring that: -current, authorized prescriber orders for medications or treatments administered by the staff are kept on file I the resident's records -communicated with the resident or responsible party -educate resident or responsible party on all medication and treatment orders, and -changes in orders are addressed in the resident's service plan and are communicated to the other staff. An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. -The licensed nurse would review all medication	01760			

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01760	Continued From page 40 and treatment orders for progress, effectiveness, and necessity on a regular basis and with resident change of condition. A resident's MAR would be audited regularly by a licensed nurse or designee for documentation compliance. The licensee's Topical Application of Ointment & Cream policy dated November 16, 2023, noted: Medication always need to be administered according to the "7" rights -right person -right medication -right time -right route (i.e., by mouth, eye drop, to the skin) -right dose (i.e. how many milligrams, drops) -right chart/record to document that the medication was taken -right reason Medication should be set up, given to the individual, and documented by the same staff member. Do not give out medications that another person has set up. To avoid confusion, it is best to give the medications as quickly as possible after they are set up. Set up the mediations for one person, give them to the person, and document that they were given before you set up the medication s for the next person. Always wash your hands before setting up medications and at any time during the process if your hands have been contaminated. Compare the information of the MAR with the label on the medication container. The following information should be in all the places: -resident name -name of the medication -the strength and dosage of the medication -the route -the time that the medication was to be given -any special instructions	01760			

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01760	Continued From page 41 Read the label and compare it with the information on the MAR three times to make sure that you haven't made a mistake. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to renew prescriptions at least every 12 months for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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: R2's diagnoses included multiple sclerosis (disease impacting the central nervous system, brain and spinal cord), weakness, dementia	01830			

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01830	Continued From page 42 associated with alcoholism, and cognitive impairment. R2's service plan dated November 27, 2024, indicated R2 received the following services: medication administration, vital sign monitoring, tubigrip (compression socking), transfer assistance, dressing and grooming assist, exercise, behavior management and housekeeping services. On December 4, 2024, at 6:16 a.m., the surveyor observed licensed practical nurse (LPN)-D adjusted R2's tubigrip stockings. R2's medication administration record (MAR) dated December 1, 2024, through December 3, 2024, included: -acetaminophen 500 milligrams (mg) (pain) two tablets, three times daily -baclofen, 10 mg (muscle spasticity) one tablet, three times daily -furosemide, 40 mg (excess fluid) daily -levetiracetam 500 mg (seizures) three tablets in the morning daily -mag-oxide 400 mg (supplement) twice daily -polyethylene glycol 17 grams (bowels) daily -potassium CL ER 10 milliequivalents (mEq) (supplement) two tablets daily -vitamin D3 2000 units (supplement) daily -Voltaren 1% gel, apply four grams (g) topically (pain) to knees twice daily -omeprazole 20 mg (stomach acid) one tablet 30 minutes prior to meal on empty stomach -simvastatin 10 mg (high cholesterol) daily at bedtime -duloxetine 60 mg (depressive disorder) daily, do not crush -melatonin three mg, (sleep) take three tablets -sertraline 100 mg (depression) daily	01830			

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01830	Continued From page 43 R2's record included: MD (medical doctor) orders certification period from: -August 30, 2022, to August 30, 2023. On December 4, 2024, at 5:42 p.m., the surveyor received a screen shot, captured December 5, 2024, that noted: -R2's orders are up to date! Next recertification date is August 9, 2025. On December 5, 2024, at 8:33 a.m., via email communication LALD-A noted R2's annual orders were signed; however, the facility was unable to locate the hard copy. The email noted the nurse practitioner (NP) who signed the original order was out on maternity leave, and the licensee had requested a copy of R2's annual orders. On December 5, 2024, at approximately 2:45 p.m., the surveyor asked LALD-A to send R2's annual orders by the end of the day on December 6, 2024. The surveyor did not receive annual orders for R2. The licensee's Medication & Treatment Orders-Renewal policy dated November 16, 2023, noted: - medication and treatment/therapy orders would be entered to the resident's authorized prescriber for signatures at least every 12 months or more frequently if medications or services are new or changed - medication and treatment/therapy orders would be updated with a resident's authorized prescriber following hospitalization, if any changes had occurred - signed medication and treatment order renewals would be placed in the resident's record.	01830			

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01830	Continued From page 44 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and 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) prepared in writing specific instructions for each resident and documented those instructions for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01950			

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01950	Continued From page 45 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: R2's diagnoses included multiple sclerosis (disease impacting the central nervous system, brain, and spinal cord), weakness, dementia associated with alcoholism, and cognitive impairment. R2's service plan dated November 27, 2024, indicated R2 received the following service: exercise, three times per day. On December 4, 2024, at 6:16 a.m., the surveyor observed LPN-D adjust R2's tubigrip stockings (compression). R2's prescriber order dated June 14, 2024, noted: -written home exercise program given to the patient/caregiver with return demonstration and understanding. R2's services delivery record dated November 1, 2024, to December 3, 2024, included exercise three times daily. R2's exercise entry active on June 18, 2024 (date entered) noted: assist the resident to participate in an exercise regiment: Use gait belt to pull up toes on right foot up 30 seconds at a time, three times daily. On December 5, 2024, at 2:08 p.m., R2's exercise program was reviewed with clinical	01950			

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01950	Continued From page 46 nurse supervisor (CNS)-C. CNS-C said R2's record did not include specific instructions for R2's exercise. CNS-C stated R2's record should include what and when staff should report to nursing, such as pain or refusals. The licensee's Treatment & Therapy Management Plan policy dated November 16, 2023, noted (name of facility) would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -documentation of specific resident instructions relating to the treatments or therapy administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			

Type: Full
Date: 12/04/24
Time: 11:36:40
Report: 8046241155

Food and Beverage Establishment Inspection Report

Page 1

Location:

Americare Lodges Inc
6870 Schultz Drive Ne
Remer, MN56672
Cass County, 11

Establishment Info:

ID #: 0039324
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2185664722
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B **** Priority 1 ****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

OBSERVED DISH MACHINE NOT HEATING TO 160F.

Comply By: 12/04/24

5-100 Water

5-102.13 **** Priority 2 ****

MN Rule 4626.1005 Water from a public water system must be sampled and tested as required by chapter 4720, rules for public water supplies.

OBSERVED MISSING WATER TESTS FROM 2023. WATER TEST FOR 2024 SCHEDULED FOR TOMORROW.

Comply By: 12/04/24

5-100 Water

5-102.14A

MN Rule 4626.1010A Water sample reports must be retained on file in the food establishment in accordance with the requirements specified in chapter 4720.

MISSING 2023 WATER TESTS.

Comply By: 12/04/24

Type: Full
Date: 12/04/24
Time: 11:36:40
Report: 8046241155
Americare Lodges Inc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: REACH IN FRIDGE
Violation Issued: No

Process/Item: Cooking
Temperature: 165 Degrees Fahrenheit - Location: CHICKEN
Violation Issued: No

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

WILL USE 2 BASIN SINK AS 3 BASIN UNTIL DISH MACHINE IS REPLACED. WILL REPLACE DISH MACHINE BY 1/4/25.

DISCUSSED: DISHES, EGGS, COOKING TEMP, CROSS CONTAMINATION, SAME DAY SERVICE.

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 8046241155 of 12/04/24.

Certified Food Protection Manager DiAnna Lucas

Certification Number: 110871 Expires: 04/06/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Desiree Heckman
Manager

Signed: Zach Johnson

Zachary Johnson R.S.
Public Health Sanitarian
Bemidji
218-308-2108
zach.johnson@state.mn.us