Electronically Delivered

May 3, 2024

Licensee
Anchor On Century
6292 Century Boulevard
Brooklyn Park, MN 55429

RE: Project Number(s) SL36788015

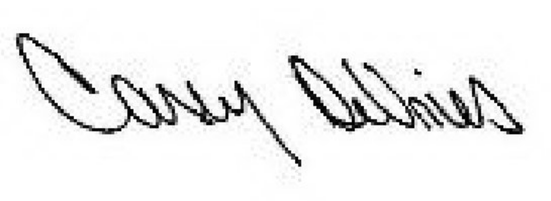
Dear Licensee:

On April 25, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 12, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36788	A. BUILDING: _____ B. WING _____	R 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR ON CENTURY	6292 CENTURY BOULEVARD BROOKLYN PARK, MN 55429

(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: SL36788015-2 On April 25, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 14, 2024. At the time of the survey, there were two residents both of whom received services under the Assisted Living license. As a result of the revisit, the licensee is in substantial compliance.	{0 000}		
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's	{0 460}		

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{0 460}	Continued From page 1 unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: No further action is required.	{0 460}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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;	{0 470}		

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{0 470}	Continued From page 2 (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action is required.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action is required.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and	{0 485}		

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{0 485}	Continued From page 3 (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action is required.	{0 485}		
{0 510} SS=D	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 is required.	{0 510}		
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults;	{0 630}		

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{0 630}	Continued From page 4 and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action is required.	{0 630}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action is required.	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements:	{0 680}		

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{0 680}	Continued From page 5 (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action is required.	{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.	{0 800}		

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{0 800}	Continued From page 6 This MN Requirement is not met as evidenced by: No further action is required.	{0 800}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning	{01500}		

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{01500}	Continued From page 7 and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action is required.	{01500}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	{01620}		

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{01620}	Continued From page 8 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: No further action is required.	{01620}		
{01640} SS=F	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	{01640}		

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{01640}	Continued From page 9 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 is required.	{01640}		
{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 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action is required.	{01760}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 15, 2024

Licensee
Anchor On Century
6292 Century Boulevard
Brooklyn Park, MN 55429

RE: Project Number(s) SL36788015

Dear Licensee:

On March 12, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on December 14, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the December 14, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on December 14, 2023, found not corrected at the time of the March 12, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4) - $500.00
0830-Local Laws Apply-144g.45 Subd. 3 - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on March 12, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. 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

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{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: SL36788015-1 On March 11, 2024, through March 12, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 14, 2023. At the time of the survey, there were two residents; both residents received services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	{0 460}		

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{0 460}	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: No further action required.	{0 460}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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;	{0 470}		

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{0 470}	Continued From page 2 (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: No further action required.	{0 470}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 485} SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	{0 485}		

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{0 485}	Continued From page 3 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action required.	{0 485}		
{0 510} SS=D	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}		

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{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action required.	{0 630}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	{0 660}		

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{0 660}	Continued From page 5 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 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=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	{0 800}		

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{0 800}	Continued From page 6 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March, at 10:45 a.m., with unlicensed personnel (ULP)-E, the surveyor made the following observations of facility hazards and disrepair: Cigarette butts were observed outside discarded on the ground around and next to the building. It was also observed cigarette butts were	{0 800}		

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{0 800}	Continued From page 7 discarded on the floor, steps, and in a plastic bucket inside the attached garage. There was an appropriate cigarette butt dispenser on the table on the back deck that was available but was not being used to dispense of the used cigarette butts in an appropriate manner. Used cigarette butts are required to be disposed of in an appropriate metallic or listed smoking container according to the facility smoking policy. During interview on March 11, 2024, at 11:00 a.m., ULP-E, stated they verified that used smoking materials were discarded outside on the ground next to the building and on the floor, steps and a plastic bucket inside the garage and not in the provided appropriate dispenser.	{0 800}		
{0 830} SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for two of two residents (R1, R2). 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	{0 830}		

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{0 830}	Continued From page 8 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 March 11, 2024, at 9:39 a.m., during the facility tour, the surveyor observed a split-level home that contained four bedrooms, with two occupied bedrooms on the upper level, and no occupied bedrooms downstairs. Upon entry to R1's room, on the inside seam of the window there was visible ash. Behind the television, there was visible ash, and a cigarette package that contained a crumpled cigarette end. Outside of the facility there were approximately over 20 cigarette ends directly below R1's window. In R2's bedroom on the inside sill of the window, there was visible ash. Some of the ash on the windowsill was smudged. Outside of the facility, below R2's window, was one cigarette end. In the unoccupied lower-level bedrooms, there were no signs of ash in the windowsills. R1 R1 admitted to the facility on December 27, 2022, and resided on the upper level of the facility. R1's diagnoses included post-traumatic stress disorder, and schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder.) R1's Service Plan (Waiver)-Addendum to Contract effective date December 11, 2023, signed December 27, 2022, indicated R1 received assistance with appointments, bathing, dressing, grooming, housekeeping, behavior	{0 830}		

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{0 830}	Continued From page 9 management, meals, socialization, transportation, and medication administration. R1's progress note dated January 21, 2024, at 11:06 a.m., indicated R1 was observed by staff smoking in their room. Staff redirected R1 and told them not to smoke in their room and R1 went outside to smoke. R1's progress note dated January 3, 2024, indicated R1 smoked in their room with their guest after they were redirected and reminded not to. R1's progress note dated December 22, 2023, indicated R1 smoked in their room and staff reminded them not to. R1's incident report dated January 21, 2024, at 3:20 a.m., indicated R1 smoked in their room, staff gave a verbal reminder of the non-smoking policy. R1's ongoing assessment dated January 5, 2024, indicated R1 had cigarette burns on the window ledge and unlicensed personnel (ULP) were to monitor R1 for complying with not smoking within the facility by performing checks on R1 in their room, downstairs, and garage. If R1 was found smoking in the facility, ULP would immediately call the supervisor and complete an incident report. If R1 continued to smoke within the facility, the registered nurse (RN) or licensed assisted living director (LALD) would initiate a care conference with the R1 and the case manager to create a plan of action for R1 to comply with not smoking in the facility. If R1 continued to smoke in the facility after the care conference, the licensee would issue a warning letter followed by a termination of contract.	{0 830}		

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{0 830}	Continued From page 10 R2 R2 admitted to the licensee on September 23, 2021, and resided on the upper level of the facility. R2's diagnoses included anxiety, depression, schizophrenia (mental disorder characterized by continuous or relapsing episodes of psychosis), and seizure disorder. R2's Service Plan (Wavier) - Addendum to Contract effective date December 11, 2023, indicated R2 received assistance with appointments, bathing reminders, bedmaking, housekeeping, laundry, behavior management, meals, blood pressure monitoring, shopping, socialization, transportation, and medication administration. R2's progress note dated January 17, 2024, 3:12 p.m., read, "[R2] took his smoking in the garage and called him out on it." R2's progress note dated January 28, 2024, at 3:36 p.m., read, "[R2] went to his room to smoke. staff reminded him of the house rules and redirected him, but resident refused to listen. Resident became agitated. Supervisor was notified and an incident report was created." R2's incident report dated January 21, 2024, at 3:00 a.m., indicated R2 smoked in their room, staff gave a verbal warning and redirection. R2's incident report dated January 28, 2024, at 9:00 a.m., indicated R2 decided it was too cold to go outside and started to smoke in their room. The staff redirected R2 verbally and the intervention was unsuccessful.	{0 830}		

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{0 830}	Continued From page 11 R2's ongoing assessment dated December 17, 2024, indicated R2 smoked and ULP were to monitor R2 for compliance of not smoking within the facility by performing checks on R2 in their room, downstairs, and garage. If R2 was found smoking in the facility, ULP would immediately call the supervisor and complete an incident report. If R2 continued to smoke within the facility, the RN or LALD would initiate a care conference with the R2 and the case manager to create a plan of action for R2 to comply with not smoking in the facility. If R2 continued to smoke in the facility after the care conference, the licensee would issue a warning letter followed by a termination of contract. On March 11, 2024, at 10:41 a.m., ULP-E stated residents were checked on in their rooms for smoking and were observed smoking on the deck. ULP-E stated they had noted the odor of cigarette smoke, documented this observation in RTasks (documenting software) as an incident report, and contacted the RN. ULP-E stated they cleaned the room last week and did not observe ash in the window or in the resident's room. On March 11, 2024, at 11:41 a.m., clinical nurse supervisor (CNS)-F stated they started to work for the licensee in February 2024. CNS-F stated R2 was started on a nicotine patch and the smoking has not been an issue "lately" and could not remember the date of the last smoking incident. CNS-F stated they had educated R2 to use nicotine gum to help with the nicotine cravings. CNS-F stated they are unaware if termination notice had been started for either resident. On March 11, 2024, at 12:23 p.m., LALD-C stated the facility had a no smoking policy. LALD-C	{0 830}		

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{0 830}	Continued From page 12 stated staff cleaned the resident rooms once per week. LALD-C stated residents were redirected outside when they were found to be smoking inside the facility and staff would complete an incident report if the resident was unable to be redirected. LALD-C stated they were unable to recall the last time a resident was found to be smoking inside the facility. LALD-C stated they hired a new CNS last month who had given education to the residents not to smoke within the facility. LALD-C stated they are unsure how long the ash had been present in the resident rooms. On March 11, 2024, at 12:54 p.m., the surveyor inquired why there was a cigarette package with a cigarette end in R1's room. LALD-C stated R1 must have smoked, and they would check RTasks for an incident report. On March 11, 2024, at 2:50 p.m., R2 stated they smoked on the deck and never smoked inside. R2 stated they were familiar with the smoking policy and did not smoke in the facility because it "is a hazard to the house." The licensee's undated Smoking Policy indicated smoking was only allowed in the designated smoking areas which included the deck, patio, and under the deck. ULP were to monitor residents' compliance with not smoking in the facility and perform checks on the residents in their room, downstairs area, and the garage. ULP were to report any non-compliant resident found smoking in the facility to supervisor and complete an incident report. If resident continued to be non-compliant with smoking in the facility, the RN or the LALD would initiate a care conference with the resident and case manager after three written incident reports to resolve the issue of smoking. In addition, if the care	{0 830}		

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{0 830}	Continued From page 13 conference was not effective and the resident continued to be non-compliant with smoking in the facility, a warning letter would be issued to the resident. If the warning letter was not effective and the resident continued to be non-compliant with smoking the licensee had the right to terminate the contract in line with the contract termination policy. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided.	{0 830}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in	{01500}		

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{01500}	Continued From page 14 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	{01500}		

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	36788	A. BUILDING: _____ B. WING _____	R 03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR ON CENTURY	6292 CENTURY BOULEVARD BROOKLYN PARK, MN 55429

(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
{01500}	Continued From page 15 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01500}		
{01620} SS=F	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: No further action required.	{01620}		

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{01640} SS=F	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}		
{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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{01760}	Continued From page 17 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		

Electronically Delivered

January 4, 2024

Licensee
Anchor On Century
6292 Century Boulevard
Brooklyn Park, MN 55429

RE: Project Number(s) SL36788015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 14, 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 - 0830 - 144g.45 Subd. 3 - Local Laws Apply = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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.

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.

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: 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
	36788	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR ON CENTURY	6292 CENTURY BOULEVARD BROOKLYN PARK, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36788015-0 On December 11, 2023, through December 14, 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 two residents, both received services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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 12, 2023, at 9:31 a.m., licensed assisted living director (LALD)-D stated they did	0 460		

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0 460	Continued From page 2 not provide means for the resident to request assistance for health and safety. LALD-D stated it was a small facility, if the residents called out from a room, a staff member would be able to hear. LALD-D stated, "Don't have in place because we don't think we need it due to the proximity of the resident." On December 12, 2023, at 11:19 a.m., during facility tour, the surveyor observed a split-level home and did not observe call lights, call pendants, or bells located in the rooms of the residents or in the common areas. On December 12, 2023, at 11:46 a.m., clinic nurse supervisor (CNS)-C stated they completed safety checks every one to two hours on the residents. In addition, CNS-C stated the residents would also come out of their rooms to request assistance from unlicensed personnel (ULP). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470		

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0 470	Continued From page 3 and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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:	0 470		

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0 470	Continued From page 4 The licensee held an assisted living license. The facility was licensed for a capacity of four residents. On December 11, 2023, at 10:39 a.m., during entrance conference, licensed assisted living director (LALD)-D stated one unlicensed personnel (ULP) worked per shift and the shifts were from 7:00 a.m. to 3:00 p.m., 3:00 p.m. until 11:00 p.m., and 11:00 p.m. until 7:00 a.m. LALD-D stated the registered nurse (RN) was on call 24 hours per day, seven days a week and was normally at the facility every Monday or as needed. Clinical nurse supervisor (CNS)-C stated they evaluated ULP for trainings and competencies, and LALD-D created and posted the weekly staffing schedule based on the resident's needs. CNS-C stated the licensee did not have a written staffing plan that included an evaluation completed by the CNS. On December 12, 2023, at 11:47 a.m., CNS-C stated they were unaware of the staffing plan requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 480	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 11, 2023, 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		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 485		

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0 485	Continued From page 6 (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; 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 require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. 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 December 11, 2023, at 9:31 a.m., licensed assisted living director (LALD)-D provided the surveyor with a blank contact and stated it was used for all resident who resided at the facility. The licensee's Assisted Living Contract page 3 included: "Subject to the Resident's needs, Anchor on Century will provide the following services which	0 485		

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0 485	Continued From page 7 are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by Anchor on Century staff at the following times: 8:00 AM Breakfast 2:00 PM Lunch 7:00 PM Dinner" The contract did not include language to inform residents they could choose which meals to purchase with their service plan. On December 12, 2023, at 12:40 p.m., LALD-D stated were aware of the requirement however, the licensee did not charge the residents for meals. LALD-D stated the licensee had contracts with the "city" (assistance programs) to pay for the meals and they do not double charge. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=D	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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(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
0 510	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of two unlicensed personnel ((ULP)-A). 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: On December 12, 2023, from 7:10 a.m. through 7:41 a.m., the surveyor observed ULP-A apply gloves, prepare breakfast, place breakfast on the dining room table for R2, gather blood pressure cuff and thermometer. With out glove removal or preforming hand hygiene ULP-A obtained R2's blood pressure and temperature, documented results in the computer system, placed used equipment back into the file cabinet, removed gloves, and washed hands. ULP-A then applied a new pair of gloves, gathered and prepared R2's medication, and administered medication to R2. Without removing gloves or preforming hand hygiene ULP-A documented medication as administered on the computer, placed medication back into the medication file cabinet, and removed gloves. Without performing hand	0 510		

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	36788	A. BUILDING: _____ B. WING _____	12/14/2023

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0 510	Continued From page 9 hygiene, ULP-A sat on the couch with the computer. ULP-A then placed a new pair of gloves, cleaned R2's room, gathered R2's used dishes from the dining room table, rinsed off R2's dishes and placed into the dishwasher, went into the living room to answer the phone, opened the medication file cabinet and searched for an unknown item, returned to kitchen sink, rinsed out dishes and placed them into the dishwasher, and removed gloves. Without performing hand hygiene ULP-A sat on the living room couch and completed documentation. ULP-A then stated they were going to prepare medication for R1 and washed hands. On December 12, 2023, at 7:51 a.m., ULP-A stated they were trained on infection control by the licensee to ensure the environment was clean and to wash hands when they complete tasks. The surveyor inquired when they were trained to perform hand hygiene. ULP-A stated when they used gloves, to prepare food, topical medication, and during medication administration. In addition, they were trained to wash their hands after glove removal. The surveyor inquired why ULP-A did not perform hand hygiene after glove removal. ULP-A stated "oh no, I didn't, sorry. But I know I should wash my hands." On December 12, 2023, at 11:47 a.m., clinical nurse supervisor (CNS)-C stated the ULP were trained via EduCare (a training software) for infection control followed by training provided by the nurse on how to apply and remove gloves. In addition, CNS-C stated ULP were trained to wash their hands prior to glove application and after glove removal. The licensee's Infection Control policy dated January 6, 2023, read, "Hands should be washed	0 510		

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0 510	Continued From page 10 at the following times. a. After changing beds b. Before assisting with medications c. Before and after treatments d. After all pet care e. After housekeeping f. After emptying bedpans g. After assisting the resident to the toilet h. After removing items from the floor i. Before preparing food j. Before feeding residents k. After using the bathroom l. After coughing or sneezing No further information provided. m. After smoking n. After handling plants o. After removing gloves" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on December 27, 2022, and began receiving assisted living services. R1's diagnoses included borderline intellectual functioning, psychosis, cannabis dependence, antisocial personality disorder, post-traumatic stress disorder (PTSD), and schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). R1's Service Plan (Wavier) - Addendum to Contract effective date December 11, 2023, indicated R1 received assistance with appointments, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, socialization, transportation, and medication administration. R1's IAPP dated November 27, 2023, indicated	0 630		

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0 630	Continued From page 12 R1 was not at risk to be abused by others however, did not include the following required content: - the person's risk of abusing other vulnerable adults. On December 12, 2023, at 12:10 p.m., clinical nurse supervisor (CNS)-C stated the licensee created a IAPP for every resident. CNS-C was unaware why R1's IAPP lacked the above content. Licensed assisted living director (LALD)-D provided the surveyor a blank Admission Assessment of what RTasks (a documenting software) IAPP covered and stated the above content was located on the document and was accidently missed during documentation for R1. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of	0 660		

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0 660	Continued From page 13 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-A). 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 facility TB risk assessment form dated February 25, 2023, indicated the facility was at a low risk for TB transmission. In addition, the licensed assisted living director was responsible for maintaining the TB screening records. ULP-A began employment with the licensee on October 1, 2016, to provide direct care and services. ULP-A's employee recorded included two health history and symptom screenings completed April	0 660		

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0 660	Continued From page 14 25, 2017, and April 25, 2023. In addition, ULP-A's employee record included step-one TST completed on July 23, 2014. The TST was completed prior to employment with licensee and lacked a second step TST. On December 12, 2023, at 10:12 a.m., licensed assisted living director (LALD)-D stated the licensee was unaware if an employee had received a TST or a blood test TB screening it would only be valid if completed within 90 days prior to employment. LALD-D stated they believed they could take the employees previous TB screening and then use the symptom health screening to ensure employees did not need another TST or blood test. LALD-D stated they took multiple employees previous TB records which were completed earlier than 90 days prior to hire, to speed up the hiring process. In addition, LALD-D stated they did not know a TST required two steps. On December 12, 2023, at 11:49 a.m., clinical nurse supervisor (CNS)-C stated when an employee was hired for the licensee, the employee either had to provide proof of screening or they were referred to a clinic to have a TST or blood test completed. CNS-C stated they reviewed employee record for documentation. The surveyor inquired how many TST an employee had to have for employment. CNS-C stated, "I think it is two steps. I don't do it." The surveyor inquired the time frame the licensee would take a previous screening for the employee when hired. CNS-C stated they believed they could take a screening from an employee if it was less than six months prior to the date of hire. The licensee's Tuberculosis Screening / Prevention policy dated January 6, 2023,	0 660		

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0 660	Continued From page 15 indicated the licensee would observe the recommended precautions related to TB prevention as identified by the CDC and the Minnesota Department of Health (MDH). The MDH Assisted living Resources and Frequently - Asked Questions (FAQs) dated December 8, 2023, indicated a previous TST or interferon- gamma release assay (IGRAs) was acceptable if completed 90 days or less prior to date of hire. The CDC's document titled TB Screening and Testing of Health Care Personnel dated May 16, 2019, indicated a TST was used to test health care personnel for TB upon hire, and two-step testing should be used. 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	0 680		

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0 680	Continued From page 16 (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to 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 emergency disaster preparedness plan lacked evidence of the following required content: - annual review; - quarterly review of missing resident policy; - strategies for addressing facility and community-based risks including staffing	0 680		

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0 680	Continued From page 17 surges/shortages, and back-up plans; - policies and procedure for medical documents; - arrangement with other facilities to include written agreements; - methods for sharing information; - subsistence needs for staff and residents; - policy and procedures for medical documents; and - emergency prep testing requirements. On December 12, 2023, at 12:58 a.m., licensed assisted living director (LALD)-D stated they last updated the emergency preparedness plan in 2022 however, the date was not documented. LALD-D stated they had verbal arrangements with other facilities in case of an evacuation. In addition, LALD-D stated they completed an emergency drill when they conducted a fire drill, however, did not document the drill that was conducted. The licensee's Emergency Preparedness policy dated January 6, 2023, indicated the licensee would have an identified plan in place to assure the safety and well-being of resident and staff during periods of an emergency or disaster that disrupts services. The emergency preparedness plan would be updated at least annually. In addition, a disaster drill would be conducted at the residence at least annually and the results of the drill would be documented. 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	0 780		

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0 780	Continued From page 18 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so 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 provide interconnected smoke alarms throughout the facility. 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	0 780		

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0 780	Continued From page 19 or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on December 11, 2023, at 1:15 p.m., with licensed assisted living director (LALD)-D, it was observed the smoke alarms were not interconnected so activation of one alarm activates all alarms inside the sleeping rooms and outside in the immediate vicinity of the sleeping rooms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and LALD-D, stated he did not know the smoke alarms were required to be interconnected. 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:	0 800		

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0 800	Continued From page 20 Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on December 11, 2023, at 1:15 p.m., with licensed assisted living director (LALD)-D, the surveyor made the following observations of facility hazards and disrepair: The Fire Safety and Evacuation Plan floor plan directed occupants of the facility to exit through the attached garage. Exit paths are required to be maintained clear and available for immediate use without passing through a room or area of higher hazard such as the garage. The occupants of the facility shall be directed to compliant required exits. It was observed that a metal mesh open garbage container with combustible materials inside was used to dispense used smoking material inside the attached garage. During interview on December 13, 2023, at 10:30, LALD-D stated the occupants do not use the	0 800		

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0 800	Continued From page 21 garage as a required exit and did not know this could not be marked as a required exit on the FSEP floor plan. LALD-D stated he discovered the discarded used smoking materials in the garbage can in the garage and has directed residents and staff to use the approved dispensers on the exterior patio to dispense of used smoking materials. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 830		

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0 830	Continued From page 22 On December 11, 2023, at 11:36 a.m., during the facility tour, the surveyor observed a split-level home that contained four bedrooms, with one occupied bedroom on the upper level, one occupied bedroom on the lower level. The surveyor noted an odor of cigarettes on the lower and upper level of the facility and a no smoking sign on the upstairs bathroom door. The facility's attached double garage had a table and chairs, and a metal trash can to place cigarettes butts in. The metal trash can was not an appropriate receptacle to extinguish cigarettes. Within 10 feet of the table in the garage was plywood and bags of raked leaves. On December 11, 2023, at 11:45 a.m., the surveyor observed R1's room and observed burn marks on two ledges, ashes near the resident's window, a Pepsi can with ashes on the top of it, and a cigarette butt and ashes on a stand near the television. R1 admitted to the facility on December 27, 2022, and resided on the lower level of the facility. R1's diagnoses included post-traumatic stress disorder, and schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder.) R1's Service Plan (Waiver)-Addendum to Contract effective date December 11, 2023, signed December 27, 2022, indicated R1 received assistance with appointments, bathing, dressing, grooming, housekeeping, behavior management, meals, socialization, transportation, and medication administration.	0 830		

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	36788	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 830	Continued From page 23 R1's Assessment by Date dated October 9, 2023, indicated R1 was assessed to smoke safely and independently without interventions and smoked six cigarettes per day. In addition, the assessment indicated R1 disposed of ashes in a bucket outside of the facility. R1's progress noted dated November 25, 2023, indicated R1 smoked in his bedroom. The progress note lacked education on smoking within the facility. R1's progress note dated November 27, 2023, indicated the licensee advised R1 to keep warm due to outdoor temperatures and indicated R1 had smoked a "couple of time" in the garage. R1's Master Care Plan dated November 27, 2023, indicated R1 was assessed to smoke safely and independently without interventions and smoked six cigarette per day. In addition, R1 disposed of ashes in a bucket outside of the facility. R1's care plan was not updated with new interventions to mitigate smoking after each episode of smoking in undesignated areas. On December 11, 2023, at 11:48 a.m., R1 stated in the summer they smoked outside but, in the winter, they smoked in the garage one to three times per day because it was too cold outside. The surveyor inquired if they smoked in their room. R1 stated, "I use to, but I stopped they did not want me to do that." R1 stated the licensee had warned them not to smoke inside the facility multiple times. The surveyor inquired why there was a cigarette butt and ashes in the room. R1 stated they brought it in from the garage. On December 11, 2023, at 11:51 a.m., licensed assisted living director (LALD)-D stated the	0 830		

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0 830	Continued From page 24 designated smoking area was outside in the yard or on the patio, however, should not be next to an entrance door. LALD-D stated in winter smoking in undesignated areas became a "regular" issue and they have to reeducate residents on designated smoking areas. The surveyor inquired if they documented the education provided to the residents. LALD-D stated in the nurse progress notes. In addition, LALD-D stated they placed two smoke detectors in resident's rooms to detect smoke quicker. On December 11, 2023, at 3:52 p.m., LALD-D stated they have attempted to contact the Office of Ombudsman however, lacked documentation of such. On December 11, 2023, at 4:17 p.m., unlicensed personnel (ULP)-A stated R1 smoked six to seven times per day in the garage and at least one time per shift in the facility. ULP-A stated they check on him at least once per shift and if they notice R1 smoking in their room they will move him to the garage. The licensee's blank contract indicated on page five, no smoking was allowed in the licensee's facility. The licensee's Fire Safety policy dated January 6, 2023, indicated there was no smoking in the building and residents may smoke in the designated area outdoors. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed	0 830		

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0 830	Continued From page 25 by walls, doorways or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 830		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control	01500		

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01500	Continued From page 26 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01500		

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01500	Continued From page 27 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of two employees (clinical nurse supervisor (CNS)-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: CNS-C was hired on October 1, 2023, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-C's employee record included one hour of dementia training dated June 26, 2023, and 45 minutes of emergency preparedness training dated June 1, 2023. CNS-C's employee record lacked eight hours of annual training completed within the last 12 months to include: - reporting maltreatment of vulnerable adults; - infection control; - assisted living bill of rights; - review of provider policies and procedures; - principles of person-centered planning/service delivery; and - dementia training (two hours required).	01500		

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01500	Continued From page 28 On December 12, 2023, 11:52 a.m., CNS-C stated they had professional education training completed for their registered nurse (RN) license. In addition, CNS-C stated they completed assisted living annual training with their other place of employment (no association to licensee) and would provide the training to the licensee for the employee record. The licensee's Staff Orientation and Education policy dated January 6, 2023, indicated all staff who provided assisted living services would complete at least eight hours of education for every 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01500		
01620 SS=F	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	01620		

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01620	Continued From page 29 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R1, 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 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: R1 R1 admitted to the licensee on December 27, 2022, and began receiving assisted living services. R1's diagnoses included borderline intellectual functioning, psychosis, cannabis dependence, antisocial personality disorder, post-traumatic stress disorder (PTSD), and schizoaffective	01620		

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01620	Continued From page 30 disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). R1's Service Plan (Wavier) - Addendum to Contract effective date December 11, 2023, indicated R1 received assistance with appointments, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, socialization, transportation, and medication administration. R1's record included 90-day nursing assessments dated July 9, 2023, and October 9, 2023. The assessment completed on October 9, 2023, indicated 92 days had passed since the previous assessment completed on July 9, 2023. R2 R2 admitted to the licensee on September 23, 2021, and began receiving assisted living services. R2's diagnoses included anxiety, depression, schizophrenia (mental disorder characterized by continuous or relapsing episodes of psychosis), and seizure disorder. R2's Service Plan (Wavier) - Addendum to Contract effective date December 11, 2023, indicated R2 received assistance with appointments, bathing reminders, bedmaking, housekeeping, laundry, behavior management, meals, blood pressure monitoring, shopping, socialization, transportation, and medication administration. R2's record included 90-day nursing assessments dated June 18, 2023, and September 18, 2023. The assessment completed	01620		

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01620	Continued From page 31 on September 18, 2023, indicated 92 days had passed since the previous assessment completed on June 18, 2023. On December 11, 2023, at 10:08 a.m., clinical nurse supervisor (CNS)-C stated the licensee completed initial assessments, 14-day assessments, ongoing assessments every 90-days, and hospital return assessments. On December 12, 2023, 11:55 a.m., CNS-C stated there was a computer error where it entered the wrong date. CNS-C stated the computer error occurred a couple times per year. In addition, CNS-C stated they generate a new assessment in the computer to be completed 90 days after previous assessment. The licensee's blank Assisted living Contract dated 2022 indicated a resident review / reassessment would be conducted in person and/or by phone and would be conducted on admission, within 14 days, every 90 days and as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	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	01640		

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01640	Continued From page 32 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 the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for two of two residents (R1, 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 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: R1	01640		

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01640	Continued From page 33 R1 admitted to the licensee on December 27, 2022, and began receiving assisted living services. R1's diagnoses included borderline intellectual functioning, psychosis, cannabis dependence, antisocial personality disorder, post-traumatic stress disorder (PTSD), and schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). R1's Service Plan (Wavier) - Addendum to Contract with an effective and printed date of December 11, 2023, (during the survey) contained a signature on the line for resident or resident representative dated December 27, 2022. The service plan indicated R1 received assistance with appointments, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, socialization, transportation, and medication administration. On December 12, 2023, at 7:41, the surveyor observed ULP-A administer medication to R1. On December 12, 2023, at 8:09 a.m., the surveyor inquired if R1 signed the service plan above on December 11, 2023. Licensed assisted living director (LALD)-D stated R1 signed the document on December 11, 2023. The surveyor inquired if R1 had another service plan completed and signed prior to the survey. LALD-D stated they would look for one. On December 12, 2023, at 8:17 a.m., LALD-D stated the licensee transitioned to electronic documenting in RTasks (a documenting software) around the time R1 admitted to the facility. LALD-D stated a service plan was completed in	01640		

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01640	Continued From page 34 RTasks however, the licensee did not print out the service plan for R1 to sign. R1 service plan lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided completed prior to the start of the survey. R2 R2 admitted to the licensee on September 23, 2021, and began receiving assisted living services. R2's diagnoses included anxiety, depression, schizophrenia (mental disorder characterized by continuous or relapsing episodes of psychosis), and seizure disorder. R2's Service Plan signed September 23, 2021, indicated R2 received 24-hour customized living service, personal care services, room and board, medication set up, vital sign monitoring, and medication administration. R2's Service Plan (Wavier) - Addendum to Contract with an effective and printed on date of December 11, 2023, indicated R2 received assistance with appointments, bathing reminders, bedmaking, housekeeping, laundry, behavior management, meals, blood pressure monitoring, shopping, socialization, transportation, and medication administration. The service plan contained a signature on the line for resident or resident representative and contained a signature on the line for facility representative, but was not dated. On December 12, 2023, the surveyor observed ULP-A administer medication to R2.	01640		

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01640	Continued From page 35 R2 service plans lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. On December 12, 2023, at 11:57 a.m., clinical nurse supervisor (CNS)-C stated for residents who came to the facility prior to changing to RTasks documentation the licensee would have the resident sign on the day of admission. CNS-C stated since the licensee started to use RTasks they entered information into the computer system and then they print it for signature. CNS-C stated administration would then obtain the signature from the resident or the resident's representative. The licensee's Service Plan policy dated January 6, 2023, indicated the initial service plan and any revisions were signed by a representative from the licensee and the resident or representative, indicating an agreement with the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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	01760		

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01760	Continued From page 36 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 follow appropriate medication administration procedures and failed to administer medications according to provider orders for one of two residents (R2). In addition, the licensee failed to accurately document medication refusal for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 R2 admitted to the licensee on September 23, 2021, and began receiving assisted living services. R2's diagnoses included anxiety, depression, schizophrenia (mental disorder characterized by continuous or relapsing episodes of psychosis),	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36788	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR ON CENTURY	6292 CENTURY BOULEVARD BROOKLYN PARK, MN 55429

(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 37 and seizure disorder. R2's Service Plan (Wavier) - Addendum to Contract effective date December 11, 2023, indicated R2 received assistance with appointments, bathing reminders, bedmaking, housekeeping, laundry, behavior management, meals, blood pressure monitoring, shopping, socialization, transportation, and medication administration. R2's Med Amin Summary - Month dated December 1, 2023, through December 31, 2023, indicated R2 was to be administered amlodipine 10 milligram (mg), chlorthalidone 50 mg, lisinopril 20 mg, ma-folic acid 1 mg, ma-vitamin B12 1000 micrograms (mcg), ma-vitamin D3 2000 units (iu), medroxyprogesterone 10 mg tablet give two tablets (20 mg), olanzapine 2.5 mg, phenytoin 100mg capsule give two tablets (200 mg), sertraline 100 mg, and tamsulosin 0.4 mg at 8:00 a.m. daily. This was a total of 11 medications in the form of 13 capsules and/or tablets. On December 12, 2023, at approximately 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-A remove R2's medication container from the locked file cabinet, open the computer screen to the electronic medication administration record (EMAR), and remove one medication card from the medication box which contained R2's medications. ULP-A described the 5 rights of medication administration to the surveyor by use of the medication card and electronic medication administration record (EMAR). ULP-A then put the one medication card back into the medication container without removing any medication from the card. ULP-A did not move the EMAR down to show more than one medication they would be administering.	01760		

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	36788	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANCHOR ON CENTURY	6292 CENTURY BOULEVARD BROOKLYN PARK, MN 55429

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01760	Continued From page 38 ULP-A then took a preset-up medication box, placed the medication from the box into the medication cup, and administered 10 unknown medications to R2. ULP-A retrieved the laptop and documented 11 medications / 13 capsules and/or tablets as being administered. The surveyor did not observe a medication count or verification of orders prior to administration. On December 12, 2023, at 7:51 a.m., ULP-A stated they attended a medication training class, and the nurse completed a medication competency prior to administering medications. The surveyor inquired why 10 medications were passed vs the 11 medications ULP-A documented on. ULP-A stated the nurse set up the medication and they acknowledged each indivdual medication that the nurse set up was administered on the EMAR. In addition, ULP-A stated, "so whatever happens, that is on the nurse, that is not on me." On December 12, 2023, at approximately 10:30 a.m., the surveyor observed R2's medication box set up by the nurse and observed 8 unknown medications set up for Sunday and Monday, 11 unknown medications set up for Wednesday, Thursday, and Friday, and 10 unknown medications set up for Saturday. In addition, the surveyor observed the medication container which held R2's medications and verified the phenytoin capsules were 100 mg each and R2 needed to receive two capsules when administered which indicated a total of 12 capsules and or pills should have been in the medication box at time of administration. The surveyor was unable to locate a card or pill bottle for medroxyprogesterone to verify if one or two tablets should have been administered. CNS-C stated they placed a note in the communication	01760		

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	36788	A. BUILDING: _____ B. WING _____	12/14/2023

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01760	Continued From page 39 book about which medications they did not place into the medication box. In addition, in RTasks (a documenting software) there was box in the EMAR that read set-up. If the set-up box was not marked with a check mark it would signify to the ULP the medication was not in the medication box. The nurse's communication book included one page of writing with three paragraphs. The top two paragraphs were undated, and the third paragraph included a date of October 16, 2023, and indicated the following: -simvastatin no Monday night; -olanzapine no Saturday, Sunday, Monday night; - unable to read medication name but stated no Sunday and Monday; - folic acid no Wednesday, Thursday, Friday, Saturday, and Monday. The communication book did not include R2's medication that was out of stock during the week of survey. R1 R1 admitted to the licensee on December 27, 2022, and began receiving assisted living services. R1's diagnoses included borderline intellectual functioning, psychosis, cannabis dependence, antisocial personality disorder, post-traumatic stress disorder (PTSD), and schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder). R1's Service Plan (Wavier) - Addendum to Contract effective date December 11, 2023, indicated R1 received assistance with appointments, bathing, dressing, grooming,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36788	A. BUILDING: _____ B. WING _____	12/14/2023

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01760	Continued From page 40 housekeeping, laundry, behavior management, meals, socialization, transportation, and medication administration. R1's Med Admin Summary - Actual - Month dated December 1, 2023, through December 31, 2023, indicated R1 received ma-vitamin D3 2000 iu, and polyethylene glycol 17 grams (g) at midday. In addition, R1's EMAR indicated R1 refused polyethylene glycol nine times from December 1, 2023, to December 11, 2023. On December 12, 2023, at 7:41 a.m., the surveyor observed ULP-A remove R1's medication from the locked file cabinet, open the computer screen to the electronic medication administration record (EMAR), remove the vitamin D3 medication card and compared it to the EMAR. ULP-A opened the preset medication box which contained two tablets of vitamin D3 1000 iu, placed medication into the medication cup, and administered medication to R1. ULP-A then documented administration of vitamin D3 on the EMAR and documented R1 refused polyethylene glycol 17 gm. The surveyor inquired why ULP-A documented R1 refused polyethylene glycol when they did not offer R1 the medication. ULP-A stated R1 had been refusing the medication so they wrote refused. ULP-A then went back to R1 and asked if they would like to take their polyethylene glycol 17 gm. R1 stated no because they were using the bathroom frequently. ULP-A documented refused on a medication prior to offering medication or receiving a response on from R1 related to taking the medication. On December 12, 2023, at 7:57 a.m., ULP-A stated if a resident refused medication, they should reapproach the resident multiple times	01760		

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01760	Continued From page 41 and then update a nurse so they could make the doctor aware of the refusal. In addition, ULP-A stated R1 had a pattern of refusing his polyethylene glycol and that is why she wrote refused and forgot to ask R1. The licensee's Medication Documentation policy dated January 6, 2023, indicated documentation would be complete, accurate, and legible. In addition, if one or more medications was not completed, staff would document why the medication was not administered, follow up procedures to meet the resident's needs in compliance with the medication management plan, appropriate notification to registered nurse (RN) supervisor or other person as instructed regarding missed dosages, and medication error report if appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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

Type: Full
Date: *12/11/23*
Time: 15:18:55
Report: 8058231288

Food and Beverage Establishment Inspection Report

Location:
Anchor On Century
6292 Century Boulevard
Brooklyn Park, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038179
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7638431469
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.

THERMAL LABEL INDICATED MACHINE REACHED A MAX OF 150 (SEE COMMENTS)

Comply By: 12/27/23

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

NO TEMPERATURE MEASURING DEVICE ON SITE (SEE COMMENTS)

Comply By: 12/27/23

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

RESIDENTIAL KITCHEN SPACE, NON COMMERCIAL EQUIPMENT AND FINISHES

HRD INSPECTOR:ASHLEY CREWS
FACILITY REP: OSAGIE EDISON EDELOOR

COMMENTS
- THERMAL LABELS OR MAX TEMP RECORDING TYPE THERMOMETER ARE NEEDED TO TRACK DISH MACHINE TEMP

Type: Full
Date: *12/11/23*
Time: 15:18:55
Report: 8058231288
Anchor On Century

Food and Beverage Establishment Inspection Report

-DETERMINE IF DISH MACHINE CAN HIT 160 WHEN RUN ON A CYCLE SPECIFIC TO SANITIZING, IF NOT, REPAIR OR REPLACE DISH MACHINE

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 8058231288 of 12/11/23.

Certified Food Protection Manager: OSAGIE EDIISON EDELOOR

Certification Number: 107957 Expires: 09/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

OSAGIE EDIISON EDELOOR
PIC

Signed: _____

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