Electronically Delivered

August 15, 2023

Licensee
Chapel View Apartments
605 Minnetonka Mills Road
Eden Prairie, MN 55343

RE: Project Number(s) SL20026015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 9, 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 . . ."

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

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

The correction order documentation should include the following:

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

specific statute(s).

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20026	A. BUILDING: _____ B. WING _____	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPEL VIEW APARTMENTS	605 MINNETONKA MILLS RD EDEN PRAIRIE, MN 55343

(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: SL20026015-0 On August 7, 2023, through August 9, 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 48 active residents; 19 receiving 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated August 7, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 800		

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0 800	Continued From page 2 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 8, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Director of Maintenance (DOM)-F, Regional Director of Operations (RDOR)-G, and Campus Administrator (CA)-H. During the facility tour, survey staff observed the following: In resident unit 412, it was observed that the bathroom exhaust fan was not working, and the fan was covered with thick dust. In the corridor by resident unit 402, it was observed that the sprinkler head was missing an escutcheon in the acoustic ceiling tile. In the laundry room on the fourth floor, it was	0 800		

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0 800	Continued From page 3 observed that the door caught the floor and did not close when the magnet door hold open was released. The door was a fire-rated door, and the rated door should close and latch completely to maintain the fire resistance integrity of the room. In the mechanical room on the fourth floor, it was observed that the door did not self close and the spring hinge did not work. The door was a fire-rated door, and the rated door should self close and latch completely to maintain the fire resistance integrity of the room. In resident unit 424, it was observed that there was a hole in the gypsum board ceiling in the bathroom. It was also observed that a considerable black stain was in the hole. During the interview, DOM-F stated that there was a water leak from the roof. In resident unit 222, it was observed that there was a considerable brown stain on the gypsum board ceiling with evidence of water damage in the bathroom. During the interview DOM-F stated that there was a water leak from unit above. In the salon on the third floor, it was observed that the magnet door held open on the wall recessed into the wall caused the wall to crack. It was also observed that the sprinkler head was covered with dark-colored dust. In the waste chute room, it was observed that the door did not self-latch and stick to the door frame. This door was identified as a rated door. In the office on the first floor, it was observed that the magnet door held open on the wall recessed into the wall caused the wall to crack.	0 800		

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0 800	Continued From page 4 In the corridor by unit 108, it was observed that there was a considerable brown stain on the acoustic ceiling tile with evidence of water damage. In the elevator lobby in the basement, it was observed that the fire-rated elevator lobby door was propped open with a block of steel. The door is required to automatically close and latch to maintain the fire barrier of the elevator lobby. The steel block would prevent the doors from closing properly in the event of a fire. It was also observed that two transfer beds from adjacent nursing rooms and many glossary carts were stored in the lobby. No equipment, furniture, or other objects shall not obstruct exits or their access thereto or egress therefrom. In the basement conference room and storage rooms, it was observed that mold or a similar black substance was on the supply air grille. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the basement served by that equipment. It was observed that the door from the egress stair to the exterior on the first floor by the dining room could not be opened easily and stuck badly to the frame. This door was identified as an exit by an overhead exit sign. It was observed that the egress door from the basement to the exterior could not be opened easily and stuck badly to the frame. This door was identified as an exit by an overhead exit sign. During the facility tour interview, DOM-F, RDOR-G, and CA-H visually verified these deficient findings at the time of discovery.	0 800		

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0 800	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide procedures necessary for resident movement, evacuation, or relocation during a fire or similar emergency with identification of unique or unusual resident needs for the movement or evacuation and failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on August 8, 2023, at approximately 1:00 p.m., with the Director of Maintenance (DOM)-F, Regional Director of Operations (RDOR)-G, and Campus Administrator (CA)-H on the fire safety and evacuation plan, fire safety and evacuation training, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include the facility-specific procedures for resident movement evacuation or relocation during a fire or similar emergency, including the identification of unique or unusual resident needs	0 810		

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0 810	Continued From page 7 for movement or evacuation. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. The policy was a basic policy developed by the corporate office and managed by the previous director of Maintenance and had not been modified to fit the facility-specific evacuation. During the interview, DOM-F stated he was not aware of any provisions in the fire safety and evacuation plan for this requirement and verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. During the interview, DOM-F stated that the licensee provided annual training to employees, but not twice per year after the initial hire, on the fire safety and evacuation plan, as required by statute. During the interview, DOM-F verified this deficient condition and confirmed that there was no further documented training for the staff on the fire safety and evacuation plan as required by statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working	01530		

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01530	Continued From page 8 hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide evidence of annual dementia care training on required topics for one of one employee (clinical nurse supervisor (CNS)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	01530		

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01530	Continued From page 9 The findings include: The licensee had a current Assisted Living Facility (ALF) license effective August 1, 2022, through September 30, 2023. CNS-D was hired into the registered nurse (RN) role on August 9, 2021, to provide supervision and oversight to unlicensed personnel and direct services for residents. CNS-D was a full-time employee and worked Monday through Friday. CNS-D's employee record included 45 minutes of dementia care training completed August 30, 2021, through September 5, 2021. CNS-D's employee records lacked eight hours of initial dementia care training within 120 working hours of the employment start date. On August 8, 2023, at 7:59 a.m. CNS-D stated, "I remember doing computer work on Relias (a computer software training system), but it is nowhere in my transcripts, so it makes sense if we get a tag on that." The licensee's Orientation and annual training-AL-MN policy dated August 1, 2021, indicated all staff must receive training that includes a current explanation of Alzheimer's disease and related disorders, effective approaches to use to problem-solve when working with a resident's challenging behaviors and how to communicate with clients who have Alzheimer's or related disorders. The assisted living provider must retain evidence, in the employee record, of each staff person having completed the required orientation.	01530		

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01530	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	01650		

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01650	Continued From page 11 Based on interview and record review, the licensee failed to ensure the service plan included all required content for three of three residents (R3, R4, and R6). 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: R3 R3 began receiving services on June 24, 2021. R3's Resident Service Plan/Agreement dated June 28, 2023, indicated R3 received services to include monthly vital signs, housekeeping, linen laundry, and catheter: empty bag. R4 R4 began receiving services on April 1, 2015. R4's Resident Service Plan/Agreement dated June 26, 2023, indicated R4 received services to include monthly vital signs, blood pressure monitoring, housekeeping, and linen laundry. R6 R6 began receiving services on September 20, 2012. R6's Resident Service Plan/Agreement dated February 12, 2023, indicated R6 received services to include bathing, AM cares, monthly	01650		

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01650	Continued From page 12 vital signs, housekeeping, and linen laundry. R2, R4, and R6's service plan lacked the following content: - medication management services and information including the frequency of medication administration. On August 8, 2023, at 12:41 p.m., clinical nurse supervisor (CNS)-D stated, "I go through the service plan with the resident or their representative, and I go through it line by line going through each service and go through each of the prices. I go through whatever treatments are on there and I use the EMAR to go through their medications. The medications and blood glucose monitoring are not on the service plans because then it was showing up on the aide's charts as needing to be checked off twice and the staff were getting confused, so we had to take it off the service plan." On August 8, 2023, at 12:43 p.m., registered nurse (RN)-A stated, "The medications and treatments should show on the service plan, that is what the service plan is for." The licensee's Service Plan (Eldermark: [a computer software system] Service Agreement) Contents AL MN policy dated March 22, 2023, indicated Service plans are reviewed and revised as needed based upon on-going resident assessment, and Service plans will include: a. A description of the services provided; b. Fees for services; c. Frequency of each service according to resident assessment and resident preferences; d. Schedule and methods of monitoring assessments; e. Schedule and methods of monitoring staff	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20026	A. BUILDING: _____ B. WING _____	08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPEL VIEW APARTMENTS	605 MINNETONKA MILLS RD EDEN PRAIRIE, MN 55343

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01650	Continued From page 13 providing services; f. Identification of staff or categories of staff who will provide the services; g. Contingency plan; h. A contingency plan that includes: i. Action taken if the scheduled service cannot be provided; ii. Information and method to contact the facility; and iii. Names and contact information of persons the resident wishes to have notified in an emergency No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that	01730		

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01730	Continued From page 14 medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content for one of four residents (R3). 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).	01730		

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01730	Continued From page 15 The findings include: R3 R3 began receiving services on June 24, 2021. R3's diagnosis included Type 2 diabetes mellitus with hyperglycemia, Urine retention unspecified, long term (current) use of insulin, Mild cognitive impairment of uncertain or unknown etiology, Delusional disorders, Malignant neoplasm of prostate. R3's Resident Service Plan/Agreement dated June 28, 2023, indicated R3 received services to include monthly vital signs, housekeeping, linen laundry, and catheter: empty bag. R3's Medication Sheet dated August 1, 2023, through August 31, 2023, included blood glucose testing check blood three times per week before breakfast, Eliquis (blood thinner) 5 milligram (mg), finasteride (used for enlarged prostate) 5 mg, Lantus (long-acting insulin) 22 units (u), Senna-S (stool softener) 8.6 mg - 50 mg, acetaminophen (pain reliever) 1000 mg as needed, glucose (sugar) 15 gel 40 percent (%), and polyethylene glycol powder (laxative) 17 grams (g). On August 8, 2023, at 7:00 a.m. the surveyor observed unlicensed personnel (ULP)-B administer morning medications to R3. R3's MN Individual Medication Management Plan dated June 14, 2023, included information on storage of insulin medications but lacked information on storage of all other medications including oral medications, powdered medications, and gel medications.	01730		

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01730	Continued From page 16 On August 9, 2023, at 8:37 a.m., clinical nurse supervisor (CNS)-D stated, "We show that [R3] has his insulin stored in fridge until opened and then stored in locked apartment. I don't see anything about where the other medications are stored but until recently he did not have any medications other that insulin so let me look in his assessment and see if I can find it there." On August 9, 2023, at 9:47 a.m., registered nurse (RN)-A via email verified the medication management plans lacked the information stated above. The licensee's Development of the individualized medication management plan and individualized medication record-AL-MN policy dated August 1, 2021, read, "Following completion of the nursing assessment, including an assessment of the resident's need for medication management, the RN develops an individualized medication management plan for the resident in conjunction with the resident and/or the resident's representative. The plan will address: a. Identification of the medication management services to be provided by our facility; b. Description of how medications managed by our facility will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 17 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider orders for one of four residents (R6). 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: R6 began receiving services on September 20, 2012. R6's Resident Service Plan/Agreement dated February 12, 2023, indicated R6 received	01760		

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01760	Continued From page 18 services to include bathing, AM cares, monthly vital signs, housekeeping, and linen laundry. R6's MN Individualized Medication Management Plan dated June 23, 2023, indicated staff administered medications for R6. R6's signed physician order sheet indicated R6 receives Miralax (a laxative solution that increases the amount of water in the intestinal tract to stimulate bowel movements) 17 grams (g) / scoop once daily. On August 8, 2023, at 7:34 a.m., the surveyor observed unlicensed personnel (ULP)-B enter R6's room to administer morning medications to include Miralax. ULP-B reviewed R6's medication administration record in the portable handheld laptop, then opened the container and poured the medication into the cap that had labeled markings that indicated 8.5 grams or 17 grams for measurements. ULP-B poured an unmeasured amount of the powder into the medication cap. The amount of medication was not significant enough to reach the measurement markings of 17 grams. ULP-B then poured the powder into the glass of water, stirred it, gave the glass to R6 then documented the administration on the handheld laptop. On August 8, 2023, at 7:45 a.m., ULP-B was asked about the dosage and how she measured R6's Miralax powder. ULP-B stated, "I should have put it on the counter and made sure it was level." On August 8, 2023, at 7:57 a.m., clinical nurse supervisor (CNS)-D stated, "The staff are all trained properly and know how to measure out powdered medications. We have a med	01760		

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01760	Continued From page 19 management packet that goes through each route. Then I train them [staff], and we do competencies for them. For Miralax, they [staff] need to make sure they use the dose cup in the cap for measuring, shake it down and make sure the powder is to the fill line, and then mix with correct amount of water indicated in the directions and then stay with them until they drink it all." The licensee's Medication administration-AL policy dated April 29, 2021, read, "Medications will be administered to residents as prescribed by the primary MD/NP/PA [Medical doctor/Nurse practitioner/Physician assistant]." 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
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/07/23*
Time: 13:00:26
Report: 1004231088

Food and Beverage Establishment Inspection Report

Location:
Chapel View Apartments
605 Minnetonka Mills Rd
Hopkins, MN55343
Hennepin County, 27

Establishment Info:
ID #: 0037570
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529382456
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.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

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

NO SMALL DIAMETER PROBE THERMOMETERS ON SITE. PROVIDE AND MAINTAIN FOR USE WITH THIN FOODS. *DINING SERVICES DIRECTOR STATED ONE WOULD BE ORDERED FOR DELIVERY THIS WEEK.

Comply By: 08/14/23

Surface and Equipment Sanitizers

Wash Temp. Gauge: = at 156 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temp. Gauge: = at 182 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Utensil Surface Temp.: = at 167 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY TESA BROWN.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*FOOD IS PREPARED IN THE NURSING HOME KITCHEN AND TRANSPORTED 3 TIMES DAILY FOR MEALS. NO PREPARING, COOKING, REHEATING, OR COOLING TAKES PLACE IN SERVICE KITCHEN.

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

*REPORT WAS DISCUSSED WITH THE DINING SERVICES DIRECTOR, ESTHER, AND WITH THE NURSE EVALUATOR, TESA.

Type: Full
Date: *08/07/23*
Time: 13:00:26
Report: 1004231088
Chapel View Apartments

Food and Beverage Establishment Inspection Report

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 1004231088 of 08/07/23.

Certified Food Protection Manager ESTHER HARVEY

Certification Number: FM3441 Expires: 05/05/24

Signed: _____
ESTHER HARVEY
DINING SERVICES DIRECTOR

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us