Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 31, 2023

Licensee
The Rosemount
14344 Cameo Avenue West
Rosemount, MN 55068

RE: Project Number(s) SL32151015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 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,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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: SL32151015-0 On July 10, 2023, through July 12, 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 96 active residents; 71 receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on July 11, 2023, at 2:17 p.m., and issued for tag identification 2310. On July 13, 2023, at 8:42 a.m., immediacy of the order was removed, the scope and level remained the same.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 10, 2023, and follow-up report dated July 12, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 510		

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0 510	Continued From page 2	0 510		

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:
Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure proper cleaning of shared assistive devices after use, between residents for two of five residents (R4, R8). Further, the licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for two of four observed staff (unlicensed personnel (ULP)-E, ULP-J).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

HAND HYGIENE

ULP-E
ULP-E was hired October 23, 2019, and provided direct care services for residents.

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0 510	Continued From page 3	0 510		

On July 10, 2023, at 11:26 a.m., ULP-E assisted R2 with blood glucose (BG) testing and insulin administration. ULP-E knocked and entered R2's room. ULP-E turned the kitchen faucet on, appeared to dispense soap into her hands, then rubbed hands together under the running water for eight seconds, dried, turned faucet off with cloth towel, and donned gloves. ULP-E used R2's Freestyle Libre (continuous blood glucose testing device) stored on R2's kitchen counter, and completed BG test for R2. ULP-E doffed gloves, and donned new gloves without cleaning her hands between glove change. ULP-E administered R2's prescribed insulin. R2 then doffed gloves, placed sharps into sharps container, and used hand sanitizer before she exited R2's apartment.

On July 10, 2023, at 11:35 a.m., ULP-E stated she had completed HH training when she was hired, and thought they were also trained annually. ULP-E indicated she was taught to sing the "ABC's" while HH was performed. ULP-E included she was nervous, and stated she did not wash her hands long enough when observed.

ULP-J
ULP-J was hired February 27, 2023, and provided direct care services for residents.

On July 11, 2023, at 7:45 a.m., ULP-J was observed administering medications to residents. ULP-J, wearing gloves, prepared medications for R10 at the medication cart. ULP-J carried medications to R10's room, approached R10 in the bathroom, and administered oral medications and an inhaled steroid medication. ULP-J returned to the medication cart, removed gloves and performed HH, rubbing hands with soap for six seconds, then four additional seconds under

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0 510	Continued From page 4	0 510		

Continued From page 4

running water, before drying. ULP-J documented the medication administration.
-at 8:07 a.m., without performing HH, ULP-J donned gloves, and prepared medications and BG testing supplies for R4. ULP-J carried oral medications, injection medications, and BG testing kit to R4's room and proceeded to administer medications and test R4's BG level.

On July 11, 2023, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to perform HH with soap and water for 20 seconds between performing cares for residents. CNS-B also included staffing has been a challenge with on-boarding new nurses, so audits have not been performed recently.

CLEANING SHARED EQUIPMENT

R4 had diagnoses including type-2 diabetes, Alzheimer's disease, and cognitive decline, and received services including assistance with medication management, and blood glucose monitoring.

R8 had diagnoses including Alzheimer's disease and received services including assistance with medication management and blood glucose monitoring.

On July 11, 2023, at 8:07 a.m., ULP-J was observed to assist R4 with BG monitoring. ULP-J, wearing gloves, opened the BG testing kit and tested R4's BG level. ULP-J stated the glucometer was used by both R4 and R8. The surveyor identified the glucometer was an Easy Touch brand. Without cleaning the glucometer, ULP-J zipped the glucometer back into the zipper pouch and returned it to the medication cart and closed the drawer.

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0 510	Continued From page 5 -at 9:50 a.m., ULP-J was observed to assist R8 with BG monitoring. ULP-J tested R8's BG level with the same meter previously used for R4. After checking R8's BG level, ULP-J zipped the glucometer back into the pouch, and returned it to the medication cart. ULP-J did not clean the glucometer before or after use by R8. ULP-J stated she cleaned the glucometer "maybe once per week" using an alcohol wipe. On July 11, 2023, at 10:40 a.m., CNS-B stated she would expect the glucometer be cleaned after each use (with alcohol) and would not be shared between residents. CNS-B stated she planned to order new glucometers so each resident could have their own. The glucometer user's manual, "Care And Storage - MHC Medical Products Easy-Touch User Manual," revised December 2011, indicated, "When cleaning the meter, gently wipe the exterior surface using a damp soft cloth DO NOT USE ANY ORGANIC SOLVENT for cleaning." The manual further indicated, "For healthcare professionals using this system on multiple patient, please be aware that all items that come in contact with human blood should be handled as potential biohazards. Users should follow the guidelines for prevention of blood-borne transmittable diseases in a healthcare setting for potentially infectious human blood specimens as recommended in the National Committee for Clinical Laboratory Standards, Protection of Laboratory Workers from Instrument Biohazards and Infectious Disease Transmitted by Blood, Body Fluids and Tissue: Approved Guideline. NCCLS document M29-A [ISBN 1-56238-339-6]." The CDC guidance, CDC's Core Infection	0 510		

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0 510	Continued From page 6	0 510		

Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated, standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications:
a. Immediately before touching a patient;
b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices;
c. Before moving from work on a soiled body site to a clean body site on the same patient;
d. After touching a patient or the patient's immediate environment;
e. After contact with blood, body fluids or contaminated surfaces; and
f. Immediately after glove removal."

The licensee's Hand Washing/Hand Hygiene policy reviewed March 20, 2023, indicated, "Hand-washing, which is the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to protect residents from the spread of infection. Hands must be washed with soap and water if visibly soiled or if working with a resident that has a GI illness. Otherwise hand washing and hand sanitizing with an alcohol based waterless sanitizing agent may be used interchangeably." Further included "g. Use friction while scrubbing vigorously for at least 15 seconds. Be sure to clean beneath the fingernails, around the knuckles and along the sides of the fingers and hands."

The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy revised March 20, 2023, included, "Reusable equipment and

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0 510	Continued From page 7 environmental surfaces will be properly disinfected after use. Whenever possible, clients will have their own reusable equipment and the equipment will not be shared with other clients or residents." Further indicated, "Glucometers must be cleaned after each use following the manufacturer's instructions." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment 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	0 800		

Minnesota Department of Health

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0 800	Continued From page 8	0 800		

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 July 12, 2023, at approximately 10:00 a.m., survey staff toured the facility with Licensed Assisted Living Director (LALD)-A and Director of Maintenance (DM-K). During the facility tour, survey staff observed the following:

In the trash room on the basement, it was observed that the fusible link and the chain were missing on the trash chute closure device at the bottom of the trash chute. The fusible link is temperature sensitive and will release in temperature rise in the event of a fire to restrict a fire from traveling up the trash chute to other levels.

In the elevator lobby on the third floor, it was observed that the fire-rated door did not close when it was tested. The door is required to close and positively latch when released from the hold-open magnet to maintain the fire integrity of the resident room and corridor for safety.

In both trash rooms on the fourth floor, it was observed that the trash chute door did not self-latch. The trash chute door should close and latch completely to maintain the fire resistance integrity of the trash chute system. With further review, both trash chute doors in trash rooms on the third floor and second floor did not self-latch either. During the interview, DM-K stated that he assumed all trash chute doors would be in the same deficient condition.

During the facility tour, LALD-A and DM-K visually

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0 800	Continued From page 9 verified these deficient findings at discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in 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	0 810		

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0 810	Continued From page 10	0 810		

drill.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to provide fire protection 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; failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills every other month. 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:

An interview and record review were conducted on July 12, 2023, at approximately 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A and the Director of Maintenance (DM-K) on the fire safety and evacuation plan, fire safety and evacuation training for the facility, 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

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0 810	Continued From page 11 resident movement evacuation or relocation during a fire or similar emergency, including the identification of unique or unusual resident needs 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 relocate. The policy was a basic policy provided by the corporate office and had yet to be implemented to fit the facility-specific plan. During the interview, LALD-A stated that he was in discussions with a neighboring school to utilize it as an emergency evacuation and temporary relocation site. LALD-A verified that the facility's fire safety and evacuation plan 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, LALD-A 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, LALD-A stated that the facility provided only one fire safety training on 2/7/23 and plan to have another training in August. LALD-A 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. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 2/7/23, 4/25/23, and 6/15/23, with no further drills being documented. During the interview, DM-K stated that he had been with	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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
0 810	Continued From page 12 the facility since last February and did not have any further record of documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01500 SS=D	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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ____ B. WING ____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

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01500	Continued From page 13 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 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

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01500	Continued From page 14	01500		

of staff are involved, or the situation has occurred only occasionally).

The findings include:

ULP-E was hired October 23, 2019, and began providing assisted living services August 1, 2021.

On July 10, 2023, at 11:26 a.m., ULP-E assisted R2 with blood glucose testing and insulin administration.

ULP-E's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics:
-review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and
-the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.

On July 12, 2023, regional director of operations (RDO)-C stated ULP-E had been assigned to complete annual Bill of Rights training in March 2023, but had not yet completed it. RDO further stated ULP-E had not completed training in person-centered planning and service delivery in the past 12 months, and added it was a scheduled upcoming course in ULP-E's online training schedule.

The licensee's Orientation and annual training-AL-MN policy, revised March 28, 2023, indicated, "All staff that perform direct assisted living services must complete at least eight (8) hours of annual training for each 12 months of employment. This training may be from the provider or outside sources and must include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	**14344 CAMEO AVENUE WEST** **ROSEMOUNT, MN 55068**

(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 a. Training on reporting of maltreatment of Vulnerable Adults b. Review of the assisted living bill of rights c. Review of infection control policies including: i. A review of hand washing techniques; ii. The need for and use of protective gloves, gowns and masks; iii. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; iv. Disinfecting reusable equipment; v. Disinfecting environmental surfaces; and vi. Reporting of communicable diseases, including tuberculosis, HIV/Aids, Hepatitis B virus and Hepatitis C. d. Review of the provider's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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 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	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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
01530	Continued From page 16	01530		

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 observation, interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of two employees (unlicensed personnel (ULP)-E).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

The licensee had an assisted living facility with dementia care (ALFDC) license, effective August 1, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	**14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068**

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01530	Continued From page 17	01530		

ULP-E was hired October 23, 2019, and began providing assisted living services August 1, 2021.

On July 10, 2023, at 11:26 a.m., ULP-E assisted R2 with blood glucose testing and insulin administration.

ULP-E's employee record lacked documentation of two hours of dementia care training completed within the previous 12 months.

On July 10, 2023, at 2:45 p.m., regional director of clinical services, registered nurse (RN)-D stated the annual Dementia care training would not be found anywhere else but in the online training transcript for ULP-E.

The licensee's Orientation and annual training-AL-MN policy, revised March 28, 2023, indicated, "Staff at all of [licensee] assisted living sites must have at least two (2) hours of training on dementia for each 12 months of employment."

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETE DATE
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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
01620	Continued From page 18	01620		

services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after admission, and not more than 90 days from the previous assessment for three of five residents (R3, R4, R5).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ____ B. WING ____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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
01620	Continued From page 19	01620		

On July 10, 2023, at 10:25 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee completed assessments upon admission, at 14 days, every 90 days, and with changes in condition.

14-DAY, and 90-DAY
R3
R3 was admitted March 9, 2023, and had diagnoses including dementia, subdural hemorrhage (bleeding in the brain), high blood pressure and anxiety.

R3's service agreement, signed June 29, 2023, indicated R3 received services including assistance with medication management, bathing, and meals.

R3's record included an initial comprehensive nursing assessment, dated March 10, 2023, and a 14-day assessment dated March 27, 2023, 18 days after start of services. Further, R3's record included a 90-day assessment completed June 29, 2023, 4 days after the assessment was due.

R4
R4 was admitted August 1, 2021, and started receiving services August 16, 2021. R4 had diagnoses including type-2 diabetes, Alzheimer's disease, and cognitive decline.

R4's service agreement, dated March 13, 2023, indicated R4 received services including assistance with medication management, blood glucose (BG) monitoring, meals, and housekeeping.

R4's record included an initial comprehensive nursing assessment, dated August 16, 2021. R4's record lacked a 14-day assessment, with the next

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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
01620	Continued From page 20	01620		

assessment completed November 3, 2021, 79 days after start of services.

R4's record included a comprehensive nursing assessment completed March 13, 2023, and a subsequent 90-day assessment completed June 23, 2023, 12 days after the assessment was due.

90-DAY
R5
R5 was admitted September 27, 2021, and had diagnoses including chronic obstructive pulmonary disease (COPD), type 2 diabetes, high blood pressure and chronic urinary retention.

R5's service agreement, signed November 23, 2022, indicated R5 received services including assistance with meals, housekeeping, reassurance checks, bathing, dressing, grooming, laundry, supra-pubic catheter care, and medication administration.

R5's record included a comprehensive nursing assessment dated March 6, 2023, and a subsequent 90-day assessment completed June 21, 2023, 18 days after the assessment was due. Further, R5's record included a comprehensive nursing assessment dated August 9, 2022, and a subsequent 90-day assessment completed March 6, 2023, 100 days after the assessment was due.

On July 12, 2023, at approximately 10:58 a.m., clinical nursing supervisor (CNS)-B stated there were no additional assessments available for R4, and agreed the assessments for R3, R4, and R5 had not been completed on schedule. CNS-B indicated the nurses are trained to run a report every week from the electronic medical record on which assessments are due. CNS-B also stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ____ B. WING ____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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
01620	Continued From page 21 she has been getting two new nurses trained and noted they are behind with some of the assessments. The licensee's Initial, Ongoing and Change in Condition Assessment-Evaluation of Residents-AL MN policy revised date January 31, 2023, included "1. A RN will coordinate the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Admission Assessment b. 14-day assessment: completed up to 14-days after start of services c. Ongoing assessment: completed periodically but no less than every 90-days d. Change in resident condition." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	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	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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 22	01760		

with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure medications were administered per providers orders and manufacturer recommendations for one of five residents (R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

R4 had diagnoses including type-2 diabetes, Alzheimer's disease, and cognitive decline.

R4's service agreement, dated March 13, 2023, indicated R4 received services including assistance with medication management, and blood glucose (BG) monitoring.

R4's record included a physician order dated May 11, 2023. The order indicated insulin aspart (novolog, a fast-acting insulin, for diabetes) 100 units/milliliter (u/ml): "Inject 0-5 units subcutaneously daily. Check BG before meals and bedtime and correct 1 unit per 50 more than 150 before meals and 1 units per 50 more than 200 at bedtime. Total daily dose 15 units", and further identified the following sliding scales for administering novolog insulin according to the identified BG level:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ____ B. WING ____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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		01760		

Continued From page 23

Before Meals
-less then 150 mg/deciliter (dl) = 0 units (U) insulin
-151-200 mg/dl = 1 u insulin;
-201-250 mg/dl = 2 u insulin;
-251-300 mg/dl = 3 u insulin;
-301-350 mg/dl = 4 u insulin;
-351-400 mg/dl = 5 u insulin; and
-401 mg/dl or more = 6 u insulin.

At Bedtime
-less then 200 mg/dl = 0 u insulin;
-201-250 mg/dl = 1 u insulin;
-251-300 mg/dl = 2 u insulin;
-301-350 mg/dl = 3 u insulin;
-351-400 mg/dl = 4 u insulin; and
-401 mg/dl or more = 5 u insulin.

R4's medication administration record (MAR) for June 15 through July 11, 2023, indicated, "Novolog 100 unit/ml soln Before meals if blood sugar is 151-200-give one unit 201-250-give 2 units; 251-300-give 3 units; 301-350-give 4 units; 351-400-give 5 units; 401 or greater-give 6 units Call nurse if blood sugar is below 100 or above 400". The MAR indicated R4 was administered novolog per sliding scale dosing daily from June 28 through July 11, 2023. The MAR included documentation of BG readings four times daily from June 15 through July 11, 2023, but lacked documentation of the actual novolog dosages administered.

On July 11, 2023, at 8:07 a.m., before breakfast, ULP-J was observed to assist R4 with BG monitoring and medication administration. ULP-J accessed R4's MAR and prepared medications including novolog. ULP-J took a glucometer in a zipper case out of the med cart, opened it, and retrieved a piece of paper with an insulin dosing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	**14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068**

(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 24	01760		

scale written on it. The surveyor observed the dosage written on the paper differed from the MAR and included the following scale:
-200 or less = 0;
-201-250 = 1 unit;
-251-300 = 2 units; and
-301-350 = 3 units.
ULP-J stated she wrote the scale out on paper so she and others could see the scale once they were in R4's room. ULP-J entered R4's room, administered oral medications, then tested R4's BG, and verbalized the reading was "279". ULP-J verbalized 2 units of novolog would be administered.
ULP-J referred to the handwritten scale and again stated she would be administering 2 u of novolog. ULP-J primed the novolog injector pen, along with two other injection pens, lantus (insulin glargine, a long-acting insulin), and victoza (for diabetes) with 2 u, dispensed into the sink. ULP-J dialed the novolog to 3 u, then back to 2 u, and stated a third time she would be administering 2 u of novolog, sliding scale insulin. The surveyor instructed ULP-J to administer lantus and victoza, but not the novolog. After lantus and victoza were administered, the surveyor and ULP-J returned to the medication cart to review the novolog dose on R4's MAR.
-at 8:33 a.m., ULP-J confirmed the MAR indicated she should have given 3 u of novolog according to the prescribed sliding scale indicated in R4's MAR. ULP-J returned to R4's room and administered 3 u of novolog per the prescribed sliding scale.

On July 11, 2023, at 10:40 a.m., clinical nurse supervisor (CNS)-B stated she would not want the ULP to write the sliding scale insulin parameters down on paper because that would not be updated with any updates to the MAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ________ B. WING ________	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(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 25 The licensee's Medication or physician orders implementation of-AL-MN policy, dated March 28, 2023, indicated, "A current, written prescriber's prescription must be obtained for any medication, including an over the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a resident. Medications are administered as prescribed." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for three of three residents (R3, R5, R7) with bed rails. This resulted in issuance of an immediate correction order on July 11, 2023. Further, the licensee failed to ensure supplemental oxygen (O2) tanks were stored safely to prevent tipping for one resident (R5) reviewed for O2 storage.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 26	02310		

Continued From page 26

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:

R3
R3 had diagnoses including dementia, chronic subdural hemorrhage (bleeding within the brain), muscle weakness, abnormal gait, and mobility.

R3's service plan dated June 29, 2023, indicated R3 received services including assistance with bathing, medication management, and meals.

On July 10, 2023, at 3:44 p.m., R3's bed was observed to be a queen-sized bed shared with her husband, R9. The bed included a consumer-style grab bar on the left side near the head of bed. The grab bar was approximately 18 inches wide, gray, u-shaped grab bar with two additional vertical bars in the center. The device was firmly secured under the mattress and had two legs on the floor for additional support.

R3's record included comprehensive nursing assessments dated March 10, 2023, and June 29, 2023. The assessments indicated R3 used "half bed rails" for bed mobility.

R3's record included a MN-Device Assessment, dated June 29, 2023. The device assessment indicated the use of "Upper assist bar/grab bar," used for transfers and bed mobility. The assessment indicated, "Risks, benefits, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	**14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 27	02310		

alternatives were discussed with the resident/resident representative and they wish to proceed with installation. The device was installed per manufacturer guidelines." The assessment further indicated the previous information was discussed with family.

On July 11, 2023, at 10:21 a.m., R3's family member (FM)-J stated she provided the grab bar to assist R9 (not R3) with bed mobility.

On July 11, 2023, at 10:40 a.m., clinical nurse supervisor (CNS)-B stated they were unable to identify the manufacturer of R3's grab bar, so had not been able to review installation instructions.

R3's record lacked documentation the consumer grab bar was checked for recalls.

R5
R5 had diagnoses including chronic obstructive pulmonary disorder (COPD) and chronic urinary retention.

R5's service plan dated November 23, 2022, indicated R5 received services including assistance with medication management, oxygen therapy, catheter care, and bathing.

On July 10, 2023, at 1:40 p.m., during medication administration, the surveyor observed a single halo-style consumer grab bar on the left side head of R5's bed. Unlicensed personnel (ULP)-G stated R5 had the grab bar for a long time but was unsure of the exact length of time.

R5's record included a comprehensive nursing assessment dated June 21, 2023. The assessment indicated R5 used "side rails on hopsital [sic] bed but does not sleep in bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ____ B. WING ____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 28	02310		

Continued From page 28

Sleeps in recliner." The assessment further indicated R5 used "half bed rails" for bed mobility.

R5's record included a MN-Device Assessment dated June 22, 2023. The device assessment lacked indication R5 used a side rail or grab bar.

R5's record included a nursing progress note dated March 22, 2022, indicating safety concerns and risk of entrapment with use of side rails was discussed with R5.

R5's record lacked documentation the consumer grab bar was checked for recalls and was installed, used, and maintained according to manufacturer's guidelines.

On July 10, 2023, at 3:10 p.m., CNS-B stated there were discrepancies in the assessments for R5 related to assistive devices. CNS-B further stated it had not been their process to check the consumer product safety commission (CPSC) for recalls of consumer bed rails.

R7
R7 had diagnoses including blindness, obstructive sleep apnea, and hearing loss. R7 received services including assistance with medication management, toileting, and assistance with activities of daily living (ADLs).

On July 11, 2023, at 7:47 a.m., R7's room was observed to have a hospital bed with bilateral upper half side rails.

On July 11, 2023, at 10:30 a.m., CNS-B stated entrapment zone measurements for R7's side rails were not documented prior to the survey time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 29	02310		

R7's record included a comprehensive nursing assessment dated June 30, 2023. The assessment lacked indication R7 used a side rail. The assessment directed, "Indicate the supporting resources for resident to get in and out of bed:", with a response, "N/A" (not applicable).

R7's record included a MN-Device Assessment dated June 30, 2023. The device assessment indicated R7 used upper half side rails for bed mobility. The assessment indicated, "Risks, benefits, and alternatives were discussed with the resident/resident representative and they wish to proceed with installation. The device was installed per manufacturer guidelines." The assessment further indicated the previous information was discussed with resident and family.

R7's record indicated the side rails were within Food and Drug Administration (FDA) measurement guidelines for entrapment zones 1-4, but lacked documentation of the measurements side rail entrapment zones.

On July 11, 2023, at 11:09 a.m., during an interview with licensed assisted living director (LALD)-A, CNS-B, registered nurse (RN)-D, and regional director of operations (RDO)-C, RN-D stated they had not been clear on the differing requirements of consumer-style grab bars versus hospital-style side rails. CNS-B stated review of the CPSC recall list and manufacturer instructions for use had not been documented prior to the survey.

The FDA guidance, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ____ B. WING ____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 30	02310		

Continued From page 30

patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."

No further information provided.

TIME PERIOD FOR CORRECTION: Immediate

An immediate correction order was identified on July 11, 2023, at 2:17 p.m., and issued for tag identification 2310.

On July 13, 2023, at 8:42 a.m., immediacy of the order was removed, the scope and level remained the same.

OXYGEN STORAGE:
R5
R5 was admitted for cares and services on September 27, 2021.

R5's service plan dated November 23, 2022, indicated R5 received services including assistance with medication management, oxygen therapy, catheter care, and bathing.

On July 10, 2023, at 1:40 p.m., surveyor observed ULP-G provide medication administration for R5. During R5's medication administration, ULP-G confirmed R5's oxygen administration using an oxygen concentrator was set at two liters per nasal cannula, according to prescribed order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32151	A. BUILDING: ______ B. WING ______	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ROSEMOUNT	14344 CAMEO AVENUE WEST ROSEMOUNT, MN 55068

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 31 On July 10, 2023, at 2:00 p.m., three large oxygen cylinders for R5 were observed with unlicensed personnel (ULP)-G to be upright, unsecured and no crate stored in the second floor extra equipment storage area labeled, "tub room." On July 10, 2023, at 2:10 p.m., clinical nurse supervisor (CNS)-B indicated she was aware the oxygen cylinders needed to be stored in a crate. CNS-B further stated, she asked the hospice provider to get these secured. CNS-B added she would look to see if the documentation of request to hospice could be found. No documentation was provided to surveyor. The licensee's Oxygen Usage (AL) policy reviewed January 31, 2023, indicated, "4. The AL does not have an oxygen storage room, nor does the AL store oxygen for residents. Oxygen company needs to provide storage: green cylinder tanks need to be stored in metal racks only." The Minnesota Department of Health Oxygen Cylinder Storage Requirements, dated April 16,2020, stated, "Cylinders must be secured (chains or racks) to prevent them from falling over." In addition, "Staff are trained on Oxygen Safety/Medical Gases." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Follow-Up
Date: *07/12/23*
Time: 14:32:48
Report: 7963231054

Food and Beverage Establishment Inspection Report

Location:
The Rosemount
14344 Cameo Avenue West
Rosemount, MN55068
Dakota County, 19

Establishment Info:
ID #: 0038728
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513224222
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 previously issued on 07/10/23 have NOT been corrected.

4-200 Equipment Design and Construction

4-204.115 ***** Priority 2 *****

MN Rule 4626.0635 Provide a temperature measuring device in the warewashing machine that indicates the temperature of the water in the wash tank, rinse tank, and the water that enters the sanitizing final rinse manifold or the chemical sanitizing solution tank.

MISSING TEMPERATURE MEASURING DEVICE FOR HOT WATER DISH MACHINES.

Issued on: 07/10/23 *Comply By: 07/11/23*

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD MANAGER EMPLOYED AT THIS LOCATION. FACT SHEET AND APPLICATION SENT TO ESTABLISHMENT.

Issued on: 07/10/23 *Comply By: 07/11/23*

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

CARE SUITES- NON OPERATIONAL DISHWASHER- REPAIR, REPLACE OR REMOVE. ARCTIC AIR COOLER RUNNING ABOVE 41 DEG F- REPAIR OR ADJUST.

Issued on: 07/10/23 *Comply By: 07/10/23*

Food and Beverage Establishment Inspection Report

No NEW orders were issued during this inspection.

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

FOLLOW-UP INSPECTION TO A FULL INSPECTION CONDUCTED ON 7/10/23.

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 7963231054 of 07/12/23.

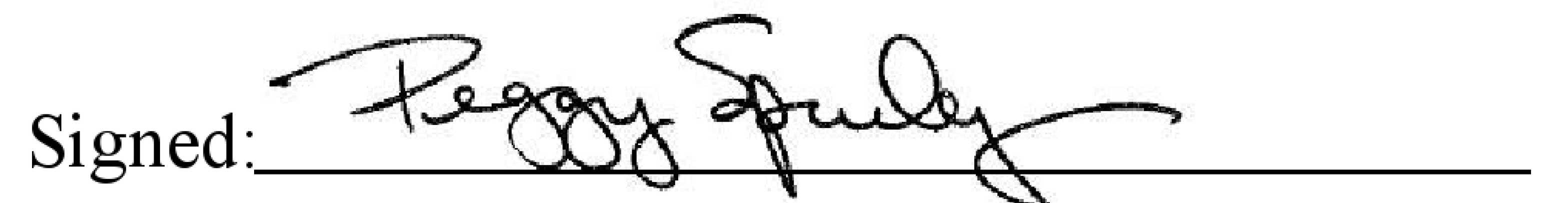
Certified Food Protection Manager:________________________________

Certification Number: ______________ Expires: / / ____________

Inspection report reviewed with person in charge and emailed.

Signed:___________________________________

Shaun Hammel
chef

Signed: 

Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *07/10/23*
Time: 09:16:00
Report: 7963231053

Food and Beverage Establishment Inspection Report

Location:
The Rosemount
14344 Cameo Avenue West
Rosemount, MN55068
Dakota County, 19

Establishment Info:
ID #: 0038728
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513224222
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

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

MAIN KITCHEN PREP TABLE- HAM AT 45 DEG F. DISCARDED AT TIME OF INSPECTION.
CARE SUITES- ARCTIC AIR COOLER MILK AT 43 DEG F. WILL BE DISCARDED AFTER DINNER SERVICE.

Comply By: 07/10/23

4-200 Equipment Design and Construction

4-204.115 ***** Priority 2 *****

MN Rule 4626.0635 Provide a temperature measuring device in the warewashing machine that indicates the temperature of the water in the wash tank, rinse tank, and the water that enters the sanitizing final rinse manifold or the chemical sanitizing solution tank.

MISSING TEMPERATURE MEASURING DEVICE FOR HOT WATER DISH MACHINES.

Comply By: 07/11/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD MANAGER EMPLOYED AT THIS LOCATION. FACT SHEET AND APPLICATION SENT TO ESTABLISHMENT.

Comply By: 07/11/23

Food and Beverage Establishment Inspection Report

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

CARE SUITES- NON OPERATIONAL DISHWASHER- REPAIR, REPLACE OR REMOVE. ARCTIC AIR COOLER RUNNING ABOVE 41 DEG F- REPAIR OR ADJUST.

Comply By: 07/10/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

MISSING HAND WASH REMINDER SIGN AT MEMORY CARE HAND SINK.

Comply By: 07/11/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANI DISPENSER
Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit
Location: MAIN DISHWASHER RINSE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: SOUP
Temperature: 148 Degrees Fahrenheit - Location: MAIN KITCHEN
Violation Issued: No

Process/Item: HARD COOKED EGGS
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: HAM
Temperature: 45 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: Yes

Process/Item: TURKEY
Temperature: 40 Degrees Fahrenheit - Location: UNDER PREP COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 38 Degrees Fahrenheit - Location: UNDER COUNTER COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: PASTRAMI
Temperature: 34 Degrees Fahrenheit - Location: WALKIN
Violation Issued: No

Process/Item: CUT MELON
Temperature: 36 Degrees Fahrenheit - Location: WALKIN
Violation Issued: No

Process/Item: SOUP
Temperature: 154 Degrees Fahrenheit - Location: CARE SUITES
Violation Issued: No

Process/Item: MILK
Temperature: 43 Degrees Fahrenheit - Location: CARE SUITES
Violation Issued: Yes

Process/Item: SOUP
Temperature: 193 Degrees Fahrenheit - Location: MEMORY CARE
Violation Issued: No

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

MET WITH CHEF SHAUN HAMMEL.

DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-CHANGES IN FOOD CODE IN 2019
-REBUILD OF CARE SUITES AREA AFTER DISH MACHINE FLOODING.

TWO FOOD SERVICE AREAS IN ADDITION TO MAIN KITCHEN-
CARE SUITES AND MEMORY CARE.
EACH AREA IS SET UP WITH COMMERCIAL REFRIGERATION, DISHWASHING AND STEAM TABLE FOR SERVICE.

Type: Full
Date: *07/10/23*
Time: 09:16:00
Report: 7963231053
The Rosemount

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 7963231053 of 07/10/23.

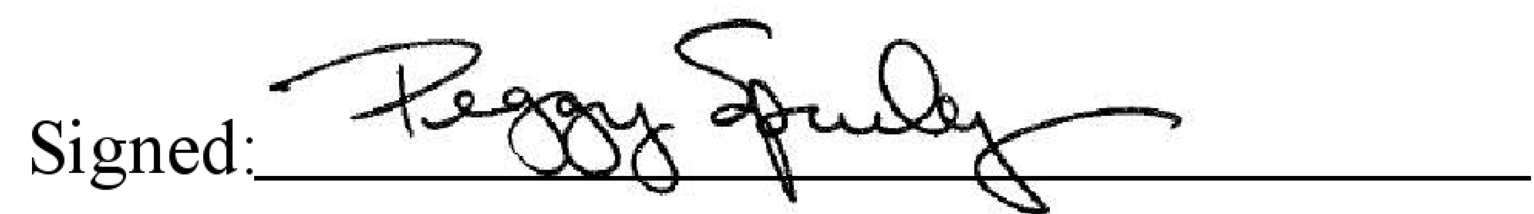
Certified Food Protection Manager: Shaun Hammel

Certification Number: ______________ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: ______________________________

Shaun Hammel
PIC

Signed: 

Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963231053

Food Establishment Inspection Report

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	3	Date	07/10/23
No. of Repeat RF/PHI Categories Out	0	Time In	09:16:00
Legal Authority MN Rules Chapter 4626		Time Out	

The Rosemount	Address	City/State	Zip Code	Telephone
	14344 Cameo Avenue West	Rosemount, MN	55068	6513224222

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038728		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R

IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS= corrected on-site during inspection R= repeat violation

#	Compliance Status (circled)	Item	COS	R
	Surpervision			
1	IN	PIC knowledgeable; duties & oversight		
2	OUT	Certified food protection manager, duties		
	Employee Health			
3	IN	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN	Proper use of reporting, restriction & exclusion		
5	IN	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN	Proper eating, tasting, drinking, or tobacco use		
7	IN	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean & properly washed		
9	IN	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food received at proper temperature		
13	IN	Food in good condition, safe, & unadulterated		
14	N/A	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN	Food separated and protected		
16	IN	Food contact surfaces: cleaned & sanitized		
17	IN	Proper disposition of returned, previously served, reconditioned, & unsafe food		
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperature		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time & temperature		
21	IN	Proper hot holding temperatures		
22	OUT	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as a public health control: procedures & records		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	N/A	Food additives: approved & properly used		
28	IN	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.
Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. COS= corrected on-site during inspection R= repeat violation

#	Status	Item	COS	R
	Safe Food and Water			
30	IN	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	N/A	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		
	Proper Use of Utensils			
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
	Utensil Equipment and Vending			
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
	Physical Facilities			
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/11/23

Inspector (Signature) [signature]