

Protecting, Maintaining and Improving the Health of All Minnesotans

#### **Electronically Delivered**

October 17, 2023

Licensee Iris Park Commons 1850 University Avenue West Saint Paul, MN 55104

RE: Project Number(s) SL23247015

Dear Licensee:

On September 27, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on June 1, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the June 1, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on June 1, 2023, found not corrected at the time of the September 27, 2023, follow-up survey and/or subject to penalty assessment are as follows:

### 0480 - Minimum Requirements - 144g.41 Subd 1 (13) (i) (b) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on September 27, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

#### **IMPOSITION OF FINES:**

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

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

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

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

Please address your cover letter for reconsideration requests to:

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

#### **REQUESTING A HEARING**

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

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

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993.

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

Sincerely,

Jonathan Hill, Supervisor State Evaluation Team

Email: jonathan.hill@state.mn.us

Telephone: 651-201-3993 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		23247	B. WING		R <b>09/27/2023</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS CITY S	STATE, ZIP CODE	0011111010
	K COMMONS	1850 UNI\		ENUE WEST	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICITIES (CORRECTION CORRECTION CORRECTI	D BE COMPLETE
{0 000}	Initial Comments		{0 000}		
	In accordance with 144G.08 to 144G.9 been issued pursual Determination of whom corrected requires or requirements provious indicated below. Whom contains several iterof the items will be compliance.  INITIAL COMMENT SL23247015-1  On September 26-2 Department of Head above provider to for pursuant to a surverthe time of the surveresidents receiving Living with Dementical designs and the surveresidents received and the surveresidents received received received received received received received received re	PROVIDER LICENSING DER  Minnesota Statutes, section 05, this correction order(s) has ant to a survey.  Therefore a violation has been compliance with all ded at the Statute number nen Minnesota Statute ms, failure to comply with any considered lack of		Minnesota Department of Health is documenting the State Correction using federal software. Tag number been assigned to Minnesota State Statutes for Assisted Living Licens Providers. The assigned tag number appears in the far left column entity Prefix Tag." The state Statute number the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficiency column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corplease DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES.  The letter in the left column is used tracking purposes and reflects the and level issued pursuant to 144G subd. 1, 2, and 3.	Orders ers have e per led "ID ber and Statute es" the e state This as eyors' rection.  OING OF  O THIS  ON FOR EATE d for scope
{0 480} SS=F	roquiromo	3) (i) (B) Minimum or make available at least the	{0 480}	Jaka. 1, 2, and 0.	
Minnocoto D	epartment of Health	or make available at least tile			

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

(X6) DATE TITLE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	?
		23247	B. WING		09/2	7/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	RK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{0 480}	Continued From pa	ge 1	{0 480}			
		residents: epared and served according ood Code, Minnesota Rules,				
	by: Based on observation review, the licensee prepared and serve	ent is not met as evidenced on, interview and record failed to ensure food was d according to the Minnesota d the potential to affect all isted living facility.				
	violation that did not safety but had the president's health or widespread scope (or represent a system)	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e:				
	and Beverage Estal	ncluded document titled, Food blishment Inspection Report, 7, 2023, for the specific de deficiencies.				
	144G.42 Subd. 10 I emergency prepare	Disaster planning and dness	{0 680}			
	contains a plan for elements of shelteritemporary relocation	meet the following mergency disaster plan that evacuation, addresses ng in place, identifies n sites, and details staff event of a disaster or an				

Minnesota Department of Health

PRINTED: 10/17/2023

Minneso	ta Department of He	alth			T OT CIVIT	AITROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		23247	B. WING		09/2	R 2 <b>7/2023</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	K COMMONS		VERSITY AV AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 680}	Continued From pa	ige 2	{0 680}			
	(3) provide building all residents; (4) post emergency and (5) have a written providents. (b) The facility must disaster training to orientation and annuake emergency and available to all residence allowed to work only working on site.	ency disaster plan prominently; emergency exit diagrams to y exit diagrams on each floor; olicy and procedure regarding all staff during the initial staff hually thereafter and must and disaster training annually dents. Staff who have not by and disaster training are ly when trained staff are also the meet any additional ted in rule.				
	This MN Requirements by: No Further Action N	ent is not met as evidenced Needed				
{0 780} SS=F	-	a) (1) Fire protection and ent	{0 780}			
		living facility must comply with in Minnesota Rules, chapter				

Minnesota Department of Health

7511, and:

of bedrooms;

the State Fire Code:

for sleeping purposes;

(1) for dwellings or sleeping units, as defined in

(ii) provide smoke alarms outside each

(iii) provide smoke alarms on each story

separate sleeping area in the immediate vicinity

within a dwelling unit, including basements, but

(i) provide smoke alarms in each room used

Minnesota Department of Health

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	23247	B. WING			R <b>27/2023</b>	
NAME OF PROVIDER OR SUP	1850 UNI	DDRESS, CITY, ST VERSITY AVE AUL, MN 5510	NUE WEST			
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
(iv) when required withing sleeping unit, that actuation the individual operate; and (v) ensures smoke alarms except that ne existing building	crawl spaces and unoccupied attics; e more than one smoke alarm is an individual dwelling unit or interconnect all smoke alarms so of one alarm causes all alarms in dwelling unit or sleeping unit to be the power supply for existing a complies with the State Fire Code, ewly introduced smoke alarms in the ings may be battery operated; uirement is not met as evidenced					
(4) keep the walls, floors, or systems, and good repair and health, safety, residents in a repair program	physical environment, including ceiling, all furnishings, grounds, equipment in a continuous state of nd operation with regard to the comfort, and well-being of the cordance with a maintenance and n.	{0 800}				
SS=E (a) An assiste provide housi	division 1 Contract required d living facility may not offer or ng or assisted living services to any ess it has executed a written the resident.	{0 900}				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	23247	B. WING		R 09/27/2023	3
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PARK COMMONS		/ERSITY AVE UL, MN 551			
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	NC (X	5)
	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
{0 900} Continued From pa	ige 4	{0 900}			
concerning the prof (1) housing; (2) assisted living s directly by the facili agreement or other (3) the resident's set (c) A facility must: (1) offer to prospect the Office of Ombut complete unsigned (2) give a complete and any addendum documents and attapromptly after a comp	ervices, whether provided ty or by management agreement; and ervice plan, if applicable.  tive residents and provide to dsman for Long-Term Care a copy of its contract; and acopy of any signed contract as, and all supporting achments, to the resident entract and any addendum has a rethic section is a consumer tions 325G.29 to 325G.37. Itime of execution of the remust offer the resident the ify a designated representative vision 3. Hent must agree in writing to be nendments to the contract. Between the resident and the fact or an addendum to the fact or an addendum to the fact is not met as evidenced.	{0 970}			
SS=F		{0 970}			
liability for the healt property of a reside include any provision	not include a waiver of facility the and safety or personal ent. The contract must not on that the facility knows or deceptive, unlawful, or				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NOIMBER.	A. BUILDING:		COMP	LETED
		23247	B. WING		R   09/2	7/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IDIO DAD	N/ OOMMONO	1850 UNI\	ERSITY AVI	ENUE WEST		
IKIS PAR	RK COMMONS	SAINT PA	UL, MN 551	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (PROVIDENCY)	D BE	(X5) COMPLETE DATE
{0 970}	Continued From pa	ge 5	{0 970}			
	include any provision lesser standard of contract required by law.	er state or federal law, nor on that requires or implies a care or responsibility than is ent is not met as evidenced leeded				
	140 Farmor Action 1	locaca				
{01470} SS=F	144G.63 Subd. 2 C	ontent of required orientation	{01470}			
	topics:  (1) an overview of t (2) an introduction a policies and proced of assisted living se person; (3) handling of eme emergency services (4) compliance with maltreatment of vul 626.557 to the Minr Center (MAARC); (5) the assisted livin responsibilities relat and protection of th (6) the principles of and service delivery support services pre (7) handling of resid complaints, and wh including information Facility Complaints; (8) consumer advoca	and review of the facility's ures related to the provision rvices by the individual staff rgencies and use of s; and reporting of the nerable adults under section resota Adult Abuse Reporting of bill of rights and staff ted to ensuring the exercise ose rights; person-centered planning and how they apply to direct ovided by the staff person; dents' complaints, reporting of ere to report complaints, n on the Office of Health				

Minnesota Department of Health

Ombudsman for Mental Health and

Developmental Disabilities, Managed Care

Ombudsman at the Department of Human

Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					F	2
		23247	B. WING		09/2	7/2023
NAME OF P	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	K COMMONS		/ERSITY AVE UL, MN 551	ENUE WEST 04		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
{01470}	Continued From page	ge 6	{01470}			
	other relevant advoces (9) a review of the transcription of the training on the aring subdivision must be based, may include include training on topics:  (1) an explanation of and how it manifest the challenges it possible to the challenges it possible to the challenges of demensionation, and depressionation, and depressionation, and depressionation, and depressionation about that may enhance of involvement, including assistive listening deand tactile alerting deaccess in real time,	ypes of assisted living yee will be providing and the flicensure. It topics in paragraph (a), It contain training on providing It swith hearing loss. Any It is provided under this It high quality and research It online training, and must It one or more of the following It age-related hearing loss It is prevalence, and It is prev				
{01500} SS=F	144G.63 Subd. 5 R	equired annual training	{01500}			
	complete at least eifor each 12 months may be obtained frosource and must income.	form direct services must ght hours of annual training of employment. The training m the facility or another clude topics relevant to the d living services. The annual				

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Minnesota Department of Health

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		23247	B. WING		09/2	7/2023
					1 00/2	172020
NAME OF PR	OVIDER OR SUPPLIER		,	STATE, ZIP CODE		
IRIS PARK	COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (PROVIDENCY)	D BE	(X5) COMPLETE DATE
	vulnerable adults urable review of the asset aff responsibilities exercise and protects. The home and implest and ards including echniques; the need of contaminated mandates are sings, needle blades; disinfecting environmental envi environmental environmental environmental environmental environm	e: ting of maltreatment of nder section 626.557; sisted living bill of rights and related to ensuring the tion of those rights; on control techniques used in ementation of infection control a review of hand washing d for and use of protective masks; appropriate disposal aterials and equipment, such es, syringes, and razor reusable equipment; mental surfaces; and cable diseases; ches to use to problem solve a resident's challenging to communicate with dementia, Alzheimer's	{01500}	DEFICIENCY)		
s ( a p	support services probable in addition to the annual training may broviding services to any training on head subdivision must be	and how they apply to direct ovided by the staff person. topics in paragraph (a), also contain training on residents with hearing loss. ring loss provided under this high quality and research online training, and must				
ii to (	nclude training on on opics:  1) an explanation of and how it manifest.	online training, and must one or more of the following of age-related hearing loss itself, its prevalence, and to communication;				

Minnesota Department of Health

Minnesota Department of Health

AND DIANIOE CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \				(X3) DATE COMP	SURVEY	
		23247	B. WING		09/2	₹ 2 <b>7/2023</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	RK COMMONS		VERSITY AVI AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01540}	incidence of dementisolation, and depression and depression and depression and that may enhance of involvement, included assistive listening depression and tactile alerting depression access in real time, access in real time, by:  No Further Action No 144G.64 (a) TRAIN	cts related to untreated loss, such as increased tia, falls, hospitalizations, ession; or ut strategies and technology communication and ing communication strategies, evices, hearing aids, visual devices, communication and closed captions.	{01540}			
SS=F	(3) for assisted livin direct-care employed least eight hours of specified under part hours of the employinitial training is comprovide direct care employee on site weight hours of training dementia care and and assist if issues requirements under meeting the requirements under available for consult until the training reconsult until the training on each 12 months of	g facilities with dementia care, ees must have completed at initial training on topics agraph (b) within 80 working ment start date. Until this aplete, an employee must not unless there is another ho has completed the initial and on topics related to who can act as a resource arise. A trainer of the paragraph (b) or a supervisor ments in clause (1) must be tation with the new employee puirement is complete. Ees must have at least two topics related to dementia for employment thereafter;				

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B WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
2324 <i>1</i>		23247	B. WING	R <b>09/27/2023</b>

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

IRIS PAR	K COMMONS	IVERSITY AVENUE WEST AUL, MN 55104		
(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
{01540}	Continued From page 9	{01540}		
	No Further Action Needed			
{01830} SS=D	144G.71 Subd. 14 Renewal of prescriptions	{01830}		
	Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.			
	This MN Requirement is not met as evidenced by: No Further Action Needed			
{01880} SS=D	144G.71 Subd. 19 Storage of medications	{01880}		
	An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.			
	This MN Requirement is not met as evidenced by:			
	No Further Action Needed			
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders	{01970}		
	There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a			
	description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:	(X3) DATE SURVEY COMPLETED
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NAME OF DOOM DED OF OURDING	0.TDEET 4.DE	DDEGG OITY OTATE ZID GODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

### 1850 LINIVERSITY AVENUE WEST

I IRIS PARK COMMONS		/ERSITY AVE UL, MN 551	ENUE WEST 04	
(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
{01970}	Continued From page 10	{01970}		
	This MN Requirement is not met as evidenced by: No Further Action Needed			
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment	{02040}		
	An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:  (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and  (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.			
	This MN Requirement is not met as evidenced by: No Further Action Needed			
{02110} SS=F	144G.82 Subd. 3 Policies  (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:	{02110}		
	(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are			

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<u> Minneso</u>	<u>ta Department of He</u>	alth	_			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	(X3) DATE COMP	
		23247	B. WING		09/2	7/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			,	ENUE WEST		
IRIS PAR	K COMMONS	SAINT PA	UL, MN 551	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{02110}	Continued From pa	ge 11	{02110}			
	(3) wandering and exprovides detailed in a resident elopes; (4) medication man assessment of resident elopes; (5) medications, including medications; (6) description of life how activities are in (7) description of factors to keep the factors to keep the factors to keep the factors and from outside mand from outside	ecific to dementia care; e enrichment programs and inplemented; mily support programs and family engaged; of public address and or emergencies and				
		ent is not met as evidenced				
	by: No Further Action N	leeded				
{03090} SS=C	144.6502, Subd. 8	Notice to Visitors	{03090}			
	entrance accessible "Electronic monitori cameras and audio record persons and (b) The facility is res	ost a sign at each facility to visitors that states: Ing devices, including security devices, may be present to activities." sponsible for installing and hage required in this				

Minnesota Department of Health

subdivision.

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D WING		R	
		23247	B. WING		09/2	7/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, S	STATE, ZIP CODE		
IRIS PAF	RK COMMONS		IVERSITY AVI AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{03090}	Continued From pa	ge 12 ent is not met as evidenced	{03090}			
	by: No Further Action N					

Minnesota Department of Health



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

Type: Follow-Up
Date: 09/27/23

Time: 11:08:15 Report: 1021231290

# Food and Beverage Establishment Inspection Report

Page 1

– Location:

Iris Park Commons

1850 University Avenue West

St Paul, MN55104 Ramsey County, 62

**License Categories:** 

Expires on: //

Establishment Info:

ID#: 0038957

Risk:

Announced Inspection: Yes

Operator:

Phone #: 6516461026

**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 05/31/23 have NOT been corrected.

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.

MILK (51F) AND GRAVY (47F) FOUND IN THE MEMORY CARE REFRIGERATOR MEASURED ABOVE 41F. SEE COMMENTS.

Issued on: 05/31/23 Comply By: 05/31/23

No NEW orders were issued during this inspection.

#### Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 51 Degrees Fahrenheit - Location: MILK - LG REFRIGERATOR, MEMORY CARE

Violation Issued: Yes

Process/Item: Cold Holding

Temperature: 47 Degrees Fahrenheit - Location: GRAVY - LG REFRIGERATOR, MEMORY CARE

Violation Issued: Yes

Process/Item: Ambient Temperature

Temperature: 47 Degrees Fahrenheit - Location: LG REFRIGERATOR, MEMORY CARE

Violation Issued: Yes

Type: Follow-Up
Date: 09/27/23
Time: 11:08:15
Report: 1021231290

Iris Park Commons

# Food and Beverage Establishment Inspection Report

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

FOLLOW-UP INSPECTION CONDUCTED WITH WITH DIRECTOR OF DINING OPERATIONS, ROBERT JONES AND LALD, JENNA KILAWEE.

TODAY'S FOLLOW UP WAS TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 5/31/23. 3 OUT OF 4 ORDERS WERE CLEARED FROM THE REPORT.

DIRECTOR WILL CALL MAINTENANCE TO ADJUST THE TEMPERATURE OF THE MEMORY CARE REFRIGERATOR. THE AMBIENT TEMPERATURE OF THE MEMORY CARE REFRIGERATOR MEASURED ABOVE 41F. STAFF WILL MOVE ANY TCS FOODS OUT OF THAT REFRIGERATOR. IF REFRIGERATOR CANNOT MAINTAIN TCS FOODS BELOW 41F THEN IT HAS TO BE REPLACED FOR A COMMERCIAL ONE.

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 1021231290 of 09/27/23.

Certified Food Protection				
Certification Number:	FM43547	Expires:	09/20/24	
Inspection report revie	ewed with pers	on in charge	and emailed	
Signed:			Signed:	MAT
ROBERT JON	ES			Melissa Ramos
DIRECTOR O	F DINING			Environmental Health Specialist
				Metro District Office
				651-201-4495

651-201-4495 Melissa.Ramos@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

#### **Electronically Delivered**

July 6, 2023

Licensee Iris Park Commons 1850 University Avenue West Saint Paul, MN 55104

RE: Project Number(s) SL23247015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

#### **STATE CORRECTION ORDERS**

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

#### **IMPOSITION OF FINES**

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual

Iris Park Commons July 6, 2023 Page 2

assault, death, or abuse resulting in serious injury.

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

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

```
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00
```

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

#### **DOCUMENTATION OF ACTION TO COMPLY**

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

The correction order documentation should include the following:

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

#### **CORRECTION ORDER RECONSIDERATION PROCESS**

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

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

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

Iris Park Commons July 6, 2023 Page 3

Please address your cover letter for reconsideration requests to:

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

#### **REQUESTING A HEARING**

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

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

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

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/01/2023
IRIS PAR	PROVIDER OR SUPPLIER  K COMMONS  SUMMARY STA	1850 UNI\	, ,	STATE, ZIP CODE  ENUE WEST  O4  PROVIDER'S PLAN OF CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
0 000	In accordance with 144G.08 to 144G.99 issued pursuant to a Determination of what requires compliance provided at the State When Minnesota Stailure to comply with considered lack of a INITIAL COMMENT SL23247015  On May 30, 2023, the Minnesota Department of the survey at the above correction orders are survey, there were streeting services to Dementia Care lices.	PROVIDER LICENSING DER(S)  Minnesota Statutes, section 5, these correction orders are a survey.  Mether violations are corrected with all requirements ute number indicated below. Eatute contains several items, the any of the items will be compliance.  TS:  Prough June 1, 2023, the ment of Health conducted a provider, and the following the issued. At the time of the 56 active residents; 30 ander the Assisted Living with these.	0 000	Minnesota Department of Health is documenting the State Correction using federal software. Tag number been assigned to Minnesota State Statutes for Assisted Living with D Care license providers. The assignumber appears in the far left coluentitled "ID Prefix Tag." The state number and the corresponding textstate Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corplease DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT T SUBMIT A PLAN OF CORRECTION."	Orders ers have ementia ned tag imn Statute at of the listed in encies" at the ne state This as eyors' rection.  DING OF  TO THIS  O DN FOR
	2310 on May 31, 20 2023, at 7:00 p.m.,	ction order was issued for 123, at 6:10 p.m. On June 1, the immediacy of the order se and level remained the		VIOLATIONS OF MINNESOTA ST STATUTES.  The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 144G subd. 1, 2, and 3.	d for scope
0 480 SS=F	144G.41 Subd 1 (13 requirements	3) (i) (B) Minimum	0 480		
Aliana a a a tan D	(13) offer to provide	or make available at least the			

IMINNESOTA DEPARTMENT OF HEAITH
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/01/2023
	PROVIDER OR SUPPLIER	1850 UNIV	ERSITY AVI	STATE, ZIP CODE ENUE WEST	
		SAINT PA	UL, MN 551	04	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
0 480	Continued From pa	ge 1	0 480		
	_ ` `	residents: epared and served according ood Code, Minnesota Rules,			
	by: Based on observati review, the licensee prepared and serve	ent is not met as evidenced on, interview and record failed to ensure food was ad according to the Minnesota ad the potential to affect all sisted living facility.			
	violation that did no safety but had the president's health or widespread scope (or represent a system)	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all			
	The findings include	e:			
	and Beverage Esta	included document titled, Food blishment Inspection Report, B, for the specific Minnesota cies.			
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one			
0 510 SS=F	(a) All assisted living maintain an infection complies with acceptance of the complete standards for t	fection control program g facilities must establish and n control program that pted health care, medical, and or infection control. ction control program must be	0 510		
		cach control program must be			

Minnesota Department of Health

STATE FORM KDFJ11 If continuation sheet 2 of 51

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		<b>l</b> `´	E CONSTRUCTION	COMPLETED		
		23247	B. WING		06/01/2023	}
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	RK COMMONS		/ERSITY AVE UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPL	ETE
0 510	Continued From page	ge 2	0 510			
U 51U	consistent with currenational Centers for Prevention (CDC) for control in long-term applicable, for infect assisted living facility (c) The facility must compliance with this This MN Requirements by:  Based on observation review, the licensee maintain an effective comply with accepted nursing standards for licensee failed to endisinfection of a glur failed to ensure directly gloved and perform 3 staff (unlicensed president's health or widespread scope (or represent a system or has the potential of the residents).  The findings include R2 had diagnoses in depression and high R2's service plan data "Resident has [methods]	ent guidelines from the Disease Control and or infection prevention and care facilities and, as tion prevention and control in ties.  I maintain written evidence of a subdivision.  Ent is not met as evidenced on, interview, and record a failed to establish and a infection control program to be dealth care, medical, and for infection control. The insure proper cleaning and cometer. Further, the licensee act care staff appropriately ed hand hygiene (HH) for 2 of the proper cleaning and cometer. Further, the licensee act care staff appropriately ed hand hygiene (HH) for 2 of the proper cleaning and cometer. Further, the licensee act care staff appropriately ed hand hygiene (HH) for 2 of the proper cleaning and a safety) and was issued at a contential to have harmed a safety) and was issued at a contential to have harmed a safety) and was issued at a contential to have pervasive emic failure that has affected to affect a large portion or all action.  Encluding type 2 diabetes, in blood pressure.  Attend May 31, 2023, indicated, incillin-resistant				
	"Resident has [method) staphylococcus auro					

Minnesota Department of Health

STATE FORM KDFJ11 If continuation sheet 3 of 51

Minnesota Department of Health

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ′	E CONSTRUCTION	COMP	LETED
		23247	B. WING		06/0	1/2023
NAME OF PROV	IDER OR SUPPLIER	1850 UNI\		STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
AL'(Prass On supin right the HA ULU pro On Ules and enter she des super enter she des	PE)] (gown, glove sisting with cather and any 30, 2023, and pervisor (CNS)-Barcart outside his urine. CNS-Barches his observed and any 31, 2023, for the sidents. Since the same of the document of the document of the document of the barches his uring with R2's uring with R2's uring with R2's uring with R2's uring with an alcohold. Without change and the cather has been declared through any point of the period of the country of the cou	sonal protective equipment es, mask, face shield) when ter or urine."  It 2:42 p.m., clinical nurse stated R2 had PPE available room because he had MRSA stated staff could wear PPE if	0 510			

Minnesota Department of Health

STATE FORM KDFJ11 If continuation sheet 4 of 51

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	23247	B. WING		06/0	06/01/2023	
	23241			06/0	1/2023	
NAME OF PROVIDER OR SUPPLIER			TATE, ZIP CODE			
IRIS PARK COMMONS		ERSITY AVE				
		UL, MN 5510			I	
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE	
0 510 Continued From pag	je 4	0 510				
the box of supplies. R2's catheter bag intrinsed the graduate, doffed one pair of glogloves in place. ULP doffed PPE including performed HH.  -at 8:33 a.m., ULP-G and entered R3's room and removed gloves, and gloves. ULP-G assist her face. R3 perform and asked for privace exited R3's room, an proceeded, with a whand down to the first breakfast for R3. ULI food for R3, retrieved doffed gloves, received and placed it on the room.  -at 8:55 a.m., ULP-G administered medical applying a topical meneck. ULP-G doffed left hand, documented donned one glove to to the garbage room No HH was observed at 9:14 a.m., without donned gloves, know ULP-G stated next stated rext stated rext stated received and placed it on the garbage room No HH was observed at 9:14 a.m., without donned gloves, know ULP-G stated next stated rext stated received and placed it on the garbage room No HH was observed at 9:14 a.m., without donned gloves, know ULP-G stated next stated received and placed it on the garbage room No HH was observed at 9:14 a.m., without donned gloves, know ULP-G stated next stated received and placed it on the garbage room No HH was observed at 9:14 a.m., without donned gloves, know ULP-G stated next stated received and placed it on the garbage room No HH was observed at 9:14 a.m., without donned gloves, know ULP-G stated next stated received and placed it on the garbage room No HH was observed at 9:14 a.m., without donned gloves, know ULP-G stated next stated received and placed it on the garbage room No HH was observed at 9:14 a.m., without donned gloves, know ULP-G stated next stated received at 9:14 a.m., without donned gloves, know ULP-G stated next stated received at 9:14 a.m., without donned gloves, know ULP-G stated next stated received at 9:14 a.m., without donned gloves, know ULP-G stated next stated received at 9:14 a.m., without donned gloves, know ULP-G stated next stated received at 9:14 a.m., without donned gloves, know ULP-G stated next stated next stated next stated received at 9:14 a.m., without donned gl	ULP-G emptied urine from to a graduate, emptied and disposed of garbage and oves, leaving a second pair of P-G then exited R2's room, g gloves, and appropriately  G donned gloves, knocked om. ULP-G assisted R3 to the oved R3's brief. ULP-G d donned a new pair of sted R3 to dress and wash ned peri care independently by. ULP-G removed gloves, and without performing HH, heeled cart, to the elevator of the floor dining room to get appear to the property of the p					

Minnesota Department of Health

STATE FORM KDFJ11 If continuation sheet 5 of 51

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
	23247	B. WING		06/0	1/2023	
NAME OF PROVIDER OR SUPP	1850 UNI	DDRESS, CITY, ST VERSITY AVE AUL, MN 5510	NUE WEST			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
gown, and sho entered R2's removed record containing a gle check his BG le removed one padditional pair returned the gle zipped it closed exposing a thir ULP-K exited Figloves. ULP-K -at 11:16 a.m., training and wathree pair of gle GLUCOMETE!  On May 31, 20 observed to as checking R2's glucometer into wheeled cart. It glucometer.  On May 31, 20 she used "purp germicidal dispinguometer at the glucometer at the glucometer.  On May 31, 20 (RN)-B stated it glucometer cle.  On June 1, 202 R2 check his be	ncluding two pair of gloves, mask, e covers. ULP-K knocked and om, and accessed R2's electronic (EMR). ULP-K unzipped a pouch accometer and assisted R2 to evel, using the glucometer, then air of gloves, exposing an of gloves on underneath. ULP-K accometer to to the pouch and a ULP-K removed gloves, d pair of gloves on underneath. C2's room, removed PPE and then performed HH appropriately. ULP-K stated she received HH is taught it was ok to wear two or oves during cares.  R CLEANING  23, at 11:19 a.m., ULP-G was sist R2 check his BG level. After BG level, ULP-G zipped the a pouch and placed it on a JLP-G did not clean the  23, at 11:30 a.m., ULP-G stated le top wipes" (sani-wipes-a osable wipe) to clean R2's he start of her shift. ULP-G stated aght how or when she should clear					

Minnesota Department of Health

STATE FORM KDFJ11 If continuation sheet 6 of 51

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY. STATE. ZIP CODE  1850 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 510  Continued From page 6  glucometer back into it's case. ULP-K did not clean the glucometer did not appear dirty, she would clean Tag. 2023, at 11:16 a.m., ULP-K stated she would clean R2's glucometer with an alcohol wipe if it appeared dirty with blood. ULP-K added if the glucometer did not appear dirty, she would clean it "once in a while," and "maybe every two weeks". ULP-K turther stated the cleaning would be done at the end of her shift.  On June 1, 2023, at 11:36 a.m., CNS-B stated staff should not be taught to wear multiple pairs of gloves during cares. CNS-B stated gloves should be changed and HH performed between residents and when moving from a dirty area to a clean area when performing cares. CNS-B stated dH4 audits had been done in the past, but not recently.  The "One Touch Ultra 2 User Guide," revised January 2019, indicated, "To clean your meter, wipe the outside with a soft cloth dampened with water and mild detergent. Do Not use alcohol or another solvent to clean your meter."  The CDC guidance titled, Hand Hygiene in		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´	E CONSTRUCTION	COMPLETED	
IRIS PARK COMMONS  SUMMARY STATEMENT OF DEFICIENCIES SAINT PAUL, MN 55104    CAG   ID   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)    O 510   Continued From page 6 glucometer back into it's case. ULP-K did not clean the glucometer.   On June 1, 2023, at 11:16 a.m., ULP-K stated she would clean R2's glucometer with an alcoholowipe if it appeared dirty with blood. ULP-K added if the glucometer did not appear dirty, she would clean it "once in a while," and "maybe every two weeks". ULP-K further stated the cleaning would be done at the end of her shift.			23247	B. WING		06/0	1/2023
CALID   SAINT PAUL, MN 55104	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D 510 Continued From page 6 glucometer back into it's case. ULP-K did not clean the glucometer.  On June 1, 2023, at 11:16 a.m., ULP-K stated she would clean R2's glucometer with an alcohol wipe if it appeared dirty with blood. ULP-K added if the glucometer did not appear dirty, she would clean it "once in a while," and "maybe every two weeks". ULP-K further stated the cleaning would be done at the end of her shift.  On June 1, 2023, at 11:36 a.m., CNS-B stated staff should not be taught to wear multiple pairs of gloves during cares. CNS-B stated gloves should be changed and HH performed between residents and when moving from a dirty area to a clean area when performing cares. CNS-B stated HH audits had been done in the past, but not recently.  The "One Touch Ultra 2 User Guide," revised January 2019, indicated, "To clean your meter, wipe the outside with a soft cloth dampened with water and mild detergent. Do Not use alcohol or another solvent to clean your meter."  The CDC guidance titled, Hand Hygiene in	IRIS PAF	RK COMMONS					
glucometer back into it's case. ULP-K did not clean the glucometer.  On June 1, 2023, at 11:16 a.m., ULP-K stated she would clean R2's glucometer with an alcohol wipe if it appeared dirty with blood. ULP-K added if the glucometer did not appear dirty, she would clean it "once in a while," and "maybe every two weeks". ULP-K further stated the cleaning would be done at the end of her shift.  On June 1, 2023, at 11:36 a.m., CNS-B stated staff should not be taught to wear multiple pairs of gloves during cares. CNS-B stated gloves should be changed and HH performed between residents and when moving from a dirty area to a clean area when performing cares. CNS-B stated HH audits had been done in the past, but not recently.  The "One Touch Ultra 2 User Guide," revised January 2019, indicated, "To clean your meter, wipe the outside with a soft cloth dampened with water and mild detergent. Do Not use alcohol or another solvent to clean your meter."  The CDC guidance titled, Hand Hygiene in	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
Healthcare Settings, dated January 8, 2021, indicated healthcare personnel (HCP) should perform HH before and after all patient contact, contact with potentially infectious material, and immediately before donning and after doffing gloves. The CDC indicated gloves should be changed and HH performed before moving from work on a soiled body site to a clean body site on the same patient. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 15 seconds.	0 510	glucometer back infolean the glucometer of the glucometer did clean R2 wipe if it appeared of the glucometer did clean it "once in a way weeks". ULP-K furth be done at the end.  On June 1, 2023, as staff should not be gloves during cares be changed and Hiresidents and when clean area when per HH audits had been recently.  The "One Touch Ult January 2019, indictive wipe the outside with water and mild deter another solvent to contact with potential immediately before gloves. The CDC in changed and HH per work on a soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient. Talcohol-based hand 95% alcohol, or was soiled bothe same patient.	to it's case. ULP-K did not er.  It 11:16 a.m., ULP-K stated ets glucometer with an alcoholdirty with blood. ULP-K added d not appear dirty, she would while," and "maybe every two her stated the cleaning would of her shift.  It 11:36 a.m., CNS-B stated taught to wear multiple pairs of a CNS-B stated gloves should herformed between moving from a dirty area to a erforming cares. CNS-B stated not done in the past, but not extra 2 User Guide," revised eated, "To clean your meter, the a soft cloth dampened with ergent. Do Not use alcohol or clean your meter."  Ititled, Hand Hygiene in a clean your meter, extra and donning and after doffing and after all patient contact, ally infectious material, and donning and after doffing dicated gloves should be exformed before moving from dy site to a clean body site on the CDC recommended I sanitizer (ABHS) with 60% to shing hands with soap and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/0	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
IRIS PAR	K COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 510	"Employees must we twenty (20) seconds non-antimicrobial so shall be performed whenever direct phytakes place. Use of washing.  a. Before and after b. If moving from a clean-body site duric. After contact with equipment in the imd. After removing gle. Before eating, had client with meals f. Before and after toileting/peri care (hwater)  h. When hands are with soap and wate i. Before and after procedures (e.g., fird.) After personal us with soap and wate k. After performing	d Washing/Hand Hygiene gust 29, 2020, indicated, rash their hands for at least is using antimicrobial or pap and water. Hand washing between client cares and raical contact with a client gloves does not replace hand direct contact with a client contaminated-body site to a nig client care in environmental surfaces or imediate vicinity of the client oves or gowns and ing food or assisting a client with personal e, bathing) assisting a client with and washing with soap and visibly soiled (hand washing r) performing any invasive nigerstick blood sampling) e of the toilet (hand washing r) your personal hygiene".	0 510			
0 680 SS=F	emergency prepare		0 680			
	(a) The facility must	meet the following				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	23247	B. WING		06/01/2023	
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	1 00/01/2020	
IRIS PARK COMMONS	1850 UNIV	ERSITY AVE	NUE WEST		
IKIS PAKK COMMONS	SAINT PA	UL, MN 5510	)4		
PREFIX (EACH DEFICIENCY MUST	INT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	ETE
(3) provide building eme all residents; (4) post emergency exit and (5) have a written policy missing residents. (b) The facility must provide disaster training to all state orientation and annually make emergency and disavailable to all residents received emergency and allowed to work only who working on site. (c) The facility must meet requirements adopted in This MN Requirement is by:  Based on observation, in review, the licensee failed emergency preparedness required content. Furthe post an emergency disasterity.	gency disaster plan that suation, addresses in place, identifies es, and details staff int of a disaster or an disaster plan prominently; ergency exit diagrams to diagrams on each floor; and procedure regarding vide emergency and aff during the initial staff of thereafter and must isaster training annually is. Staff who have not id disaster training are en trained staff are also et any additional in rule.  Is not met as evidenced enterview and record ed to develop a written es (EP) plan with all the er, the licensee failed to ester plan prominently. In a flect all residents, staff in a level two violation (a ring a resident's health or initial to have harmed a erty, but was not likely to	0 680			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNI\	ERSITY AVE	STATE, ZIP CODE ENUE WEST		
		SAINT PA	UL, MN 551	04		
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 680	Continued From pa	ge 9	0 680			
	problems are perva	espread scope (when sive or represent a systemic cted or has potential to affect I of the residents).				
	The findings include	e:				
	entrance area and a first floor, white elev	at 12:02 p.m., the facility front a posting area located by the rator were observed. Both ted emergency disaster plan.				
	2021, lacked document and customization to resident-specific incoming: - a risk assessment may impact all or a - an assessment of and - a communication contact information	azards Plan, dated May 31, nentation of annual review, to the facility and dividualization including the considering all hazards that portion of the facility; the at risk population's needs; plan that included names and for staff, resident physicians,				
	living director (LALE that the emergency reviewed annually, plan would need to related to specific haresponses including emergency contact plan with information staff.  The licensee's [Lice May 31, 2021, indicated to specific haresponses including emergency contact plan with information staff.	t 6:30 p.m., licensed assisted D)-A stated she understood preparedness plan be and stated it made sense the be customized for the location azards, and specific the acuity level and information for residents and information for residents and n for communicating with ensee] All Hazards Plan dated ated, "[Licensee] shall then sive Emergency Plan, an Incident Command System				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
IRIS PARK COMMONS			STATE, ZIP CODE ENUE WEST 04			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 680	be developed and restaff. The plan will a required for a succeptant will include the mitigation, emergences response; recovery shall be maintained federal regulations.	nanagement guidelines shall nade widely available to all address the major components essful Emergency Plan. The essential components of risk ncy preparedness, emergency and also education. The plan in accordance with state and "The plan further indicated, cies are reviewed and nnually."  On was provided.  R CORRECTION:	0 680			
0 780 SS=F	(a) Each assisted I the State Fire Code 7511, and:  (1) for dwellings or the State Fire Code (i) provide smooth for sleeping purpos (ii) provide smooth separate sleeping a of bedrooms;  (iii) provide smooth within a dwelling unnot including crawled (iv) where more required within an insleeping unit, interest that actuation of one	iving facility must comply with in Minnesota Rules, chapter sleeping units, as defined in the larms in each room used	0 780			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		23247	B. WING		06/0	1/2023
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
IRIS PAR	K COMMONS		UL, MN 551	ENUE WEST 04		
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 780	Continued From pa	ge 11	0 780			
	smoke alarms comexcept that newly in	power supply for existing plies with the State Fire Code, troduced smoke alarms in ay be battery operated;				
	by: Based on observation failed to provide small fire protection requi	ent is not met as evidenced on and interview, the licensee loke alarms that complied with rements. This deficient otential to affect all staff, ors.				
	violation that did not safety but had the president's health or cause serious injury was issued at a wide problems are perva	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety, but was not likely to y, impairment, or death), and espread scope (when sive or represent a systemic cted or has potential to affect I of the residents).				
	Findings include:					
	p.m., survey staff to of maintenance (DN director (LALD)-A, a (MS)-E. During the observed the follow 1. Smoke alarms w sleeping rooms of r 201, 213, and 309. 2. A smoke alarm w sleeping area in the	ere not installed in the esident apartments 109, 113, as not installed outside the immediate vicinity of the				
	bedroom in resident 3. In unit 302, the si	t apartment 310. moke alarms did not test as				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/0	1/2023
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STATE, ZIP CODE	1 00/0	1/2020
IRIS PAR	K COMMONS			ENUE WEST		
			UL, MN 551			T.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 780	Continued From pa	ge 12	0 780			
		nat actuation of one alarm the dwelling unit to operate.				
		ditions were verified by DM-D, accompanying on the facility				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
0 800 SS=D		) (4) Fire protection and nt	0 800			
	walls, floors, ceiling systems, and equip good repair and open health, safety, comf	cal environment, including, all furnishings, grounds, ment in a continuous state of eration with regard to the fort, and well-being of the ance with a maintenance and				
	by: Based on observation of the failed to maintain the including walls, floor grounds, systems, a state of good repair the health, safety, or residents. This deficients	ent is not met as evidenced on and interview, the licensee e physical environment, rs, ceiling, all furnishings, and equipment in a continuous and operation with regard to omfort, and well-being of the cient condition had the I staff, residents, and visitors.				
	violation that did not safety but had the president's health or isolated scope (whe	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety) and was issued at an en one or a limited number of ed or one or a limited number				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00047	B WING		00/04/2022	
		23247	D. WING		06/01/2023	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
IRIS PAF	RK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST na		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)	<u> </u>
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLI	ETE.
0 800	Continued From pa	ge 13	0 800			
	of staff are involved only occasionally).	, or the situation has occurred				
	Findings include:					
	p.m., survey staff to of maintenance (DN director (LALD)-A, a (MS)-E. During the apartment 219, surv	between 11:00 a.m. and 1:30 bured the facility with director (I)-D, licensed assisted living and maintenance supervisor facility tour, in resident vey staff observed that the arm did not provide an audible by DM-D.				
	This deficient condition was verified by DM-D, LALD-A, and MS-E, accompanying on the facility tour.					
	TIME PERIOD FOR days	R CORRECTION: Two (2)				
0 900 SS=E	144G.50 Subdivisio	n 1 Contract required	0 900			
	provide housing or individual unless it he contract with the result (b) The contract much concerning the provided (1) housing; (2) assisted living sedirectly by the facility agreement or other (3) the resident's sed (c) A facility must: (1) offer to prospect the Office of Ombuc complete unsigned	ervices, whether provided by or by management				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		23247	B. WING		06/0	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	K COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04		
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 900	Continued From pa	ge 14	0 900			
	and any addendumed documents and attar promptly after a combeen signed.  (d) A contract under sective (e) Before or at the contract, the facility opportunity to identification according to subdive (f) The residency additions or amough additions o	s, and all supporting achments, to the resident intract and any addendum has a this section is a consumer ions 325G.29 to 325G.37. Itime of execution of the must offer the resident the fy a designated representative ision 3. In the end and the end to the contract. In the end to the end				
	RT's service plan, d	ated February 14, 2022,				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMP	SURVEY	
		23247	B. WING		06/0	1/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, S	TATE, ZIP CODE		
			VERSITY AVE			
IRIS PAF	RK COMMONS	SAINT PA	AUL, MN 5510	)4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 900	Continued From pa	ge 15	0 900			
	assistance with acti meals, medication r	ed services including vities of daily living (ADLs), management, compression housekeeping, and laundry.				
		ovember 2, 2020, and began ving services on August 1,				
	indicated R2 received	lated November 15, 2021, ed services including dication management, blood oring, catheter care, laundry.				
	contract, titled Resident August 22, 2018, and respectively. The restriction of their updated assisted liven 2021, including the in a conspicuous produced the legal nation of the the name, telephological and the licensee of the managing applicable; and	representative received an ring contract after August 1, following: place and manner on the ame and the health facility facility; ne number, and physical nich may not be a public or lox, of: the facility; gent of the facility, if				
	- a disclosure of the facility license held - the right under sector an assistance of the facility license held - the right under sector an assistance of June 1, 2023, at living director (LALE)	agent for the facility. category of assisted living by the facility; and ction 144G.54 to appeal the ssisted living contract. t 12:04 p.m., licensed assisted 0)-A stated the contract was nd was sent out to all residents				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	E CONSTRUCTION	COMF	PLETED
		23247	B. WING		06/	01/2023
	ROVIDER OR SUPPLIER	1850 UNI\		STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	Continued From particles or their representations and documentations. No further information of the PERIOD FOR Twenty-One (21) days	ve, but they had not received on for R1 and R2. on was provided. R CORRECTION:	0 900			
SS=F	The contract must reliability for the health property of a reside include any provisions should know to be dunenforceable under include any provision lesser standard of contract did not incl	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety) and was issued at a when problems are pervasive emic failure that has affected to affect a large portion or all	0 970			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
IRIS PAF	RK COMMONS		ERSITY AVE	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 970	Continued From pa	ge 17	0 970			
		eptember 10, 2018, and began ving services on August 1,				
	indicated R1 receive assistance with acti meals, medication r	ated February 14, 2022, ed services including vities of daily living (ADLs), management, compression housekeeping, and laundry.				
		ovember 2, 2020, and began ving services on August 1,				
	indicated R2 received	ated November 15, 2021, ed services including dication management, blood oring, catheter care, laundry.				
	R3 was admitted De	ecember 29, 2022.				
	R3 received service activities of daily livi	ated April 3, 2023, indicated so including assistance with ng (ADLs), meals, medication ekeeping, and laundry.				
	living contract, titled signed August 22, 2 December 6, 2022, The contract include the contract, indicated Section 9 - NO LIAB	Residency Agreement, 2018, October 1, 2020, and respectively. led the following language in ing a waiver of liability: BILITY OF MANAGEMENT y of Resident; No Liability of				
	"Management has rany third party for a	no responsibility to Resident or ny personal property placed in ny other location within [facility]				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNI\		STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 970	personal property. It responsible to Resident as loss of any of Resident as loss of any of Resident release, indemnify, Management harm with respect to harm Resident's personal On June 1, 2023, at living director (LALE updated in 2021, are or their representations signed documentations of June 1, 2023, at they would need to liability in the contrast. No further informations.	esident or the owner of such Management is not dent or any third party for loss perty by theft or any other sumes all risks for harm to or lent's personal property, and defend, and hold less from any and all liability in to or loss of any of I property."  It 12:04 p.m., licensed assisted D)-A stated the contract was and was sent out to all residents ive, but they had not received ion for R1 and R2.  It 12:51 p.m., LALD-A stated look further at the waivers of act.	0 970			
01470 SS=F	<ul> <li>(a) The orientation topics:</li> <li>(1) an overview of topics:</li> <li>(2) an introduction applicies and proced of assisted living separates</li> <li>(3) handling of emergency services</li> <li>(4) compliance with</li> </ul>	and review of the facility's ures related to the provision rvices by the individual staff	01470			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	COMPI	
		23247	B. WING		06/0	1/2023
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
IRIS PAR	RK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (PROVIDER OF CORRECTION SHOUL)	.D BE	(X5) COMPLETE DATE
	Center (MAARC); (5) the assisted living responsibilities related and protection of the (6) the principles of and service delivery support services processor (7) handling of residuality complaints, and who including information Facility Complaints; (8) consumer advocable Combudsman for Loudsman for Medical Disagraphics; Ombudsman at the Combudsman at th	nesota Adult Abuse Reporting  In a bill of rights and staff ted to ensuring the exercise ose rights; person-centered planning of and how they apply to direct ovided by the staff person; dents' complaints, reporting of ere to report complaints, n on the Office of Health  cacy services of the Office of ng-Term Care, Office of	01470			
	services the employ facility's category of (b) In addition to the orientation may also services to resident training on hearing subdivision must be based, may include include training on topics:  (1) an explanation of and how it manifest the challenges it por (2) health impacts it age-related hearing incidence of dementisolation, and depressions.	ypes of assisted living yee will be providing and the flicensure. It topics in paragraph (a), contain training on providing s with hearing loss. Any loss provided under this high quality and research online training, and must one or more of the following of age-related hearing loss is itself, its prevalence, and ses to communication; elated to untreated loss, such as increased itia, falls, hospitalizations, ession; or ut strategies and technology				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/0	1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	RK COMMONS		/ERSITY AVE UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
01470	assistive listening dand tactile alerting dand tactile alerting daccess in real time,  This MN Requirements by: Based on observation review, the licensed received orientation required content, for (registered nurse (F. (ULP)-F).  This practice results violation that did not safety but had the president's health or widespread scope (or represent a system or has the potential of the residents).  The findings include RN-C RN-C was hired August direct care and asset of the facility.  RN-C's employee rether following orients an overview of asset an introduction and policies and proced assisted living services assisted living services person;  -the principles of persons.	ing communication strategies, evices, hearing aids, visual devices, communication and closed captions.  ent is not met as evidenced on, interview and record failed to ensure employees to assisted living, including all r two of two employees (N)-C, unlicensed personnel ed in a level two violation (at harm a resident's health or otential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all		DEFICIENCY)		
		ovided by the staff person;				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/01/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAF	RK COMMONS		/ERSITY AVI UL, MN 551			
(V 4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
01470	Continued From pa	ge 21	01470			
01470	-handling of resider complaints, and whincluding information Facility Complaints; -consumer advocate Ombudsman for Med Developmental Disa Ombudsman at the Services, county-material other relevant advocated ULP-F ULP-F was hired Fed providing direct care Assisted Living with August 1, 2021.  On May 31, 2023, at observed to assist for the following orients and overview of assisted living services and proceed assisted living services on;	ere to report complaints, non the Office of Health and ey services of the Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services.  Ebruary 26, 2021, and began e services under the licensees Dementia Care license on et 1:12 p.m., ULP-F was R6 with toileting.  Fecord lacked documentation ation topics were completed: isted living MN statutes 144G; I review of the facility's ures related to the provision of ces by the individual staff				
	services;	encies and use of emergency				
	626.557 to the Minr Center (MAARC);	nerable adults under section lesota Adult Abuse Reporting				
	service delivery and	rson-centered planning and I how they apply to direct				
	-handling of resider complaints, and wh	ovided by the staff person; its' complaints, reporting of ere to report complaints, n on the Office of Health				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNI\	DRESS, CITY, S VERSITY AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01470	Ombudsman for Lo Ombudsman for Me Developmental Disa Ombudsman at the Services, county-mother relevant advora review of the type the employee will be category of licensur. On June 1, 2023, as living director (LALI general orientation, orientation topics, as kills and competer completed all orients stated they would not completed orientation. The licensee's "Hor dated August 28, 20, 144G statutes for a indicated orientation."-An overview of Mi Statutes I44A.43 to -An introduction and policies and proced home care services. Handling emergen services; -Reporting the malt or adults under Min 626.557; -The home care bill I44A.44); -Our program's systesponding to comp	cy services of the Office of ng-Term Care, Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services; and es of assisted living services e providing and the facility's re.  It 4:59 p.m. licensed assisted D)-A stated as part of the staff were assigned the and upon completion of their ncies, they should have ration requirements. LALD-A eed more reliable way to track red orientation.  The Care Orientation" policy, 220, was not updated with ssisted living licensure, but a would include: nnesota's home care law (MN 144A.4798); direview of all of our agency's ures related to the provision of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/01/2023
	PROVIDER OR SUPPLIER	1850 UNI\	ERSITY AVE	STATE, ZIP CODE  ENUE WEST	
			UL, MN 551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
01470	Entry Point and how contact these agend. The consumer adv Ombudsman for Lo Ombudsman for Me Developmental Disa Ombudsman at the Services, county may other relevant advoragency's license."  No further information	plaints and the Common vicients, staff and others may cies with complaints; ocacy services of the ng-Term Care, Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services; and es of home care services the oviding and the scope of our	01470		
01500 SS=F	(a) All staff that performed at least eifor each 12 months may be obtained from source and must include (1) training must include (1) training on report vulnerable adults ure (2) review of the assistant responsibilities exercise and protection (3) review of infection the home and implest standards including techniques; the need gloves, gowns, and	form direct services must ght hours of annual training of employment. The training om the facility or another clude topics relevant to the d living services. The annual e: ting of maltreatment of nder section 626.557; sisted living bill of rights and related to ensuring the ction of those rights; on control techniques used in ementation of infection control a review of hand washing and for and use of protective masks; appropriate disposal aterials and equipment, such	01500		

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		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		, 20.20			
2	23247	B. WING		06/0	1/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
IRIS PARK COMMONS		ERSITY AVE			
		UL, MN 5510			
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01500 Continued From page 24		01500			
as dressings, needles, syriblades; disinfecting reusable disinfecting communicable di (4) effective approaches to when working with a reside behaviors, and how to comresidents who have demer disease, or related disorde (5) review of the facility's prelating to the provision of and how to implement thos procedures; and (6) the principles of personand service delivery and he support services provided (b) In addition to the topics annual training may also coproviding services to reside Any training on hearing los subdivision must be high quality based, may include online include training on one or topics:  (1) an explanation of agerand how it manifests itself, challenges it poses to com (2) the health impacts related hearing loss, sincidence of dementia, falls isolation, and depression;  (3) information about strate that may enhance community of the providing conassistive listening devices, and tactile alerting devices access in real time, and cleans the support is real time.	ple equipment; surfaces; and iseases; o use to problem solve ent's challenging nmunicate with ntia, Alzheimer's ers; policies and procedures assisted living services se policies and n-centered planning ow they apply to direct by the staff person. s in paragraph (a), ontain training on ents with hearing loss. ss provided under this quality and research training, and must more of the following related hearing loss , its prevalence, and nmunication; ted to untreated such as increased s, hospitalizations, or egies and technology nication and nmunication strategies, hearing aids, visual s, communication osed captions.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNI\	, ,	STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01500	review, the licensed received at least eight for each 12 months employees (register personnel (ULP)-F)  This practice results violation that did not safety but had the president's health or widespread scope (or represent a system or has the potential of the residents).  The findings included RN-C RN-C was hired Augusties and assembly of the facility.  RN-C's employee register to a system of the facility.  RN-C's employee register to a system of the facility.  RN-C's employee register to a system of the facility.  RN-C's employee register to a system of the facility.  RN-C's employee register to a system of the facility.  RN-C's employee register to a system of the facility.  RN-C's employee register to a system of the facility.  RN-C's employee register to a system of the facility.  RN-C's employee register to a system of the facility.  RN-C's employee register to a system of the facility.	on, interview and record e failed to ensure employees ght (8) hours of annual training of employment for two of two red nurse (RN)-C, unlicensed .  ed in a level two violation (a tharm a resident's health or otential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e:  gust 21, 2021, and provided essment services for residents  ecord lacked documentation of al training completed within including the following  ted living bill of rights and staff ted to ensuring the exercise ose rights; control techniques used in the intation of infection control a review of hand washing of for and use of protective masks; appropriate disposal aterials and equipment, such es, syringes, and razor reusable equipment; mental surfaces; and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> `´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
23247		B. WING		06/01/2023	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PARK COMMONS		/ERSITY AVE UL, MN 551	ENUE WEST 04		
(X4) ID SUMMARY STATEMENT OF DEF PREFIX (EACH DEFICIENCY MUST BE PREC TAG REGULATORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
continued From page 26  -review of the facility's policies a relating to the provision of assist and how to implement those poliprocedures; and -the principles of person-centere service delivery and how they apsupport services provided by the ULP-F ULP-F was hired February 26, 2 providing direct care services un Assisted Living with Dementia C August 1, 2021.  On May 31, 2023, at 1:12 p.m., I observed to assist R6 with toileti  ULP-F's employee record lacked of eight hours of annual training the last 12 months, including the required topic: -the principles of person-centere service delivery and how they apsupport services provided by the On May 30, 2023, at 4:04 p.m., I living director (LALD)-A stated at was assigned through the online program.  On June 1, 2023, at 4:59 p.m., L they would need a more reliable completion of required training.  No further information was provi	ed living services icies and ed planning and oply to direct e staff person.  O21, and began icensees are license on on one of the licensees are license on one of the license on one of th	01500	DEFICIENCY)		

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AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
	23247	B. WING		06/0	1/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PARK COMMONS		ERSITY AVE UL, MN 551	ENUE WEST 04		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION (CORRECTIVE APPROPERTION (CORRECTIVE APPROPERTION (CORRECTIVE APPROPERTION (CORRECTIVE ACTION (CORRECTION (CORRE	.D BE	(X5) COMPLETE DATE
01540 Continued From pa	ge 27	01540			
01540 SS=F REQUIRED	ING IN DEMENTIA CARE	01540			
direct-care employed least eight hours of specified under part hours of the employ initial training is comprovide direct care employee on site weight hours of training dementia care and and assist if issues requirements under meeting the require available for consuluntil the training reconsuluntil the training on each 12 months of the care training in the care training in the two employees (regunlicensed personn records reviewed.  This practice results violation that did no safety but had the president's health or widespread scope or represent a system.	g facilities with dementia care, ees must have completed at initial training on topics agraph (b) within 80 working ment start date. Until this inplete, an employee must not unless there is another ho has completed the initial ing on topics related to who can act as a resource arise. A trainer of the paragraph (b) or a supervisor ments in clause (1) must be tation with the new employee quirement is complete. ees must have at least two topics related to dementia for employment thereafter; ent is not met as evidenced on, interview and record a failed to ensure direct-care required amount of dementia required time frame for two of pistered nurse (RN)-C, and (ULP)-F), with employee end in a level two violation (a tharm a resident's health or cotential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/01/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
IRIS PAR	IRIS PARK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
01540	Continued From pa	ge 28	01540		
	The findings include	e:			
		current Assisted Living Facility (ALFDC) license effective			
		gust 21, 2021, and provided essment services for residents			
	RN-C's employee record included documentation of 6.25 hours of dementia training. The record lacked documentation of completion of 8 hours of dementia care training completed within 80 hours of working, including: -principles of person-centered planning and service delivery.				
		ecord lacked documentation of tia care training completed			
	providing direct care	ebruary 26, 2021, and began e services under the licensees Dementia Care license on			
	On May 31, 2023, a observed to assist F	nt 1:12 p.m., ULP-F was R6 with toileting.			
	The record lacked of 8 hours of demendant within 80 hours of within 80	record included .5 hours of dementia training. documentation of completion htia care training completed working including the following			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
	IRIS PARK COMMONS			STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPERTION (PROPERTION OF CORRECTION OF	.D BE	(X5) COMPLETE DATE
01540	-communication skit-principles of person service delivery.  ULP-F's employee of documentation of ocare training. The retwo hours of demer annually.  On June 1, 2023, at living director (LALE the required demendent would need to compensure it was doned need more reliable required dementia of the licensee's demendated August 28, 20 direct care staff hire also have at least enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated," Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated," Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated," Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated," Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated," Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated," Enthe topics specified hours of the employ further indicated, "Enthe topics specified hours of the employ further indicated hours of the employ further indicat	th challenging behaviors; lls; and n-centered planning and record included ne hour of annual demential ecord lacked documentation of atia care training completed to 4:59 p.m. licensed assisted D)-A stated they assigned all tia care training to staff, but blete training record audits to LALD-A stated they would way to track completion of care training.  The policy of initial training on below within 120 working ament start date." The policy Direct-care staff hired January complete at least eight hours the topics specified below hours of the employment start.				
01830 SS=D	144G.71 Subd. 14 F	Renewal of prescriptions	01830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNI\	, ,	STATE, ZIP CODE  ENUE WEST  04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01830	months or more freassessment in subscontrolled substance 152.  This MN Requirement by: Based on observation review, the licenses were renewed at leasthree residents (R2).  This practice results violation that did not safety but had the president's health or isolated scope (who residents are affect of staff are involved only occasionally).  The findings include R2 was admitted Not receiving assisted liagonal properties and laundry.  On May 31, 2023, and laundry.  On May 31, 2023, and laundry.  R2's medication administration.  R2's medication administration.	be renewed at least every 12 quently as indicated by the division 2. Prescriptions for es must comply with chapter ent is not met as evidenced on, interview and record failed to ensure prescriptions ast every 12 months for one of at harm a resident's health or obtential to have harmed a safety) and was issued at an en one or a limited number of ed or one or a limited number of et as it under the situation has occurred es:  Devember 2, 2020, and began aving services on August 1, services including assistance nagement, blood glucose at the er care, housekeeping,  at 11:22 a.m., unlicensed assisted R2 with medication eministration record (MAR) for direct R2 was administered the	01830			

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STATE FORM KDFJ11 KDFJ11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		22247	B. WING		00/6	14/2022
		23247	D. WING		06/0	01/2023
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
IRIS PAF	RK COMMONS		VERSITY AV UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
01830	Continued From pa	ge 31	01830			
	-finasteride (for pros- furosemide (for war- jardiance (for diabe- lantus (insulin-for diabe- lisinopril (for high be- metformin (for diabe- myrbetriq (for urina- naltrexone hydroch dependence), 50 me- venlafaxine (for de- mirtazapine (for de- tamsulosin (for urina-	state), 5 mg; ster retention), 20 mg; etes), 10 mg; diabetes), 100 u/ml; blood pressure), 5 mg; betes), 500 mg; ary health), 25 mg; hloride (HCL) (for alcohol				
	March 17, 2022. Th	ne record lacked updated not the last 12 months.				
	On June 1, 2023, at 11:36 a.m., clinical nurse supervisor (CNS)-C stated the orders in R2's record were the most current orders they had. CNS-C further stated they would get signed orders when residents were newly admitted or when orders changed.					
		t 4:04 p.m., registered nurse ed orders needed to be nonths.				
	No further informati	on was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01880 SS=D		Storage of medications	01880			
	substantially constr	acility must store all acility must store all acility must store all acides in securely locked and ucted compartments and anufacturer's directions and				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
		23247	B. WING		06/0	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	RK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01880	Continued From pa	ge 32	01880			
	permit only authoriz	ed personnel to have access.				
	by: Based on observation review, the facility for personnel had accept for one of three residents are affect violation that did not safety but had the president's health or isolated scope (where residents are affect of staff are involved only occasionally). The findings include R3's service plan, do R3 had diagnoses in hypertension and deservices including a service of staff are involved only occasionally).	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety) and was issued at an en one or a limited number of ed or one or a limited number l, or the situation has occurred e:				
	May 2023, indicated following medication -amlodipine (for hig milligrams (mg); -alendronate (for os-acetaminophen (for open content)	teoporosis), 70 mg; r pain), 1000 mg; nloride (HCL) (for depression), pression), 20 mg; pain), 2 grams (g); ), 400 mg; rgies), 10 mg;				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		` ′	(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/0	01/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	RK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01880	constipation); -tramadol (opioid, for-donepezil (for demi-estradiol cream (for-latanoprost eye dro-tizanidine (for back) On May 31, 2023, a observed assisting had a wheeled cart surveyor observed medication cup that sitting on the cart. Unito R2's room. R2 assistance, so ULP knocked and enteredoor, leaving the carunattended in the hibedroom, and attended in the hibedroo	the glycol (PEG) powder (for our pain), 25 mg; tentia), 10 mg; tentia), 10 mg; tentia), 2 mg.  It since a small, white, paper to contained oral medications, JLP-G knocked and looked indicated he was not ready for e.G went to R3's room. ULP-G ed R3's room, and closed the lit with the medication cup allway. ULP-G entered R3's not to the hallway and the core and left the wheeled cart cup in the hallway. ULP-G walked feet down the hall, leaving the loor. ULP-G entered a hallway ormed hand hygiene (HH). G returned to the cart with the mg on it. G wheeled the cart to R3's es, knocked, and entered with lation cup. ULP-G assisted R3 ly living (ADLs) and then	01880			
		ith the medication cart, and				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNIV		TATE, ZIP CODE  ENUE WEST  04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01880	ULP-G then returned at 8:50 a.m., ULP-compared the medications as them. ULP-G stated usually used for medications as them. ULP-G stated usually used for medications with emedications with emed	for to get breakfast for R3. Indicated to R3's room. It is stated she already had R3's in the medication cup on the stated she used the tration record (MAR) when cations, and would document administered after R3 takes if that was the process she edication administration. It is accessed R3's MAR and is medications in the cup. It is in front of R3 and left veyor observed R3 take the later, showing the pills to the later that the later than t	01880			
01970 SS=D	There must be an use electronically record prescriber for all tresorder must contain description of the treprovided, and the frequency	reatment and therapy orders  up-to-date written or ded order from an authorized atments and therapies. The the name of the resident, a eatment or therapy to be equency, duration, and other to administer the treatment or	01970			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		23247	B. WING		06/01/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
IRIS PAR	RK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
01970	Continued From pa	ge 35	01970		
	therapy. Treatment renewed at least ev	and therapy orders must be ery 12 months.			
	Based on observation review, the licenses orders for all treatments the frequency, duration needed to administ one of three resider.  This practice results violation that did not safety but had the president's health or cause serious injury was issued at an isolimited number of realimited number of realimited number of	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).			
	R2 had diagnoses including type 2 diabetes mellitus, neurogenic bladder dysfunction, and major depression.				
	indicated R2 received	ated November 13, 2021, ed services including dication management, blood oring, catheter care, laundry.			
	May 2023 indicated with the following tro-blood sugar checks and at bedtime; and	s 15-30 minutes before meals			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	COMPLETED		
		23247	B. WING		06/0	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	RK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04		
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01970	Continued From pa	ge 36	01970			
	for supra-pubic cath	neter care.				
	R2's record included March 17, 2022, incomplete order significated, "Recently needing daily wound care [registered nur (suprapubic)". The signed within the last on June 1, 2023, at supervisor (CNS)-Corecord were the modern CNS-Corecord were the modern of the signed orders when admitted or when order or a treatment signed by the presence of the provided; consistent with the corder must compare the consistent with the corder must compare the consistent with the co	d prescriber orders signed dicating blood sugar checks 5-30 minutes before meals and ford further included an gned April 5, 2022, which is got suprapubic catheter did dressing" and "OK for home rise (RN)] to eval/treat wound record lacked updated orders at 12 months.  It 11:36 a.m., clinical nurse is stated the orders in R2's at current orders they had. It is determined they would, typically, get in residents were newly reders changed.  It 4:04 p.m., registered nurse and orders needed to be nonths.  It and Treatment and Therapy last 29, 2020, indicated, "An interact or therapy must be dated, wriber and must be current and client's nursing assessment. Italin:				
	e. Any parameter or modify the therapy,	r instructions to 'hold' or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNI\		STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01970	therapy the order material instructions regarding treatment or therapy. The policy further in Health Professional renews a treatment every 12 months, or determined necessal assessment."	is for a PRN treatment or lust include specific ing when to administer the y." idicated, "The RN or Licensed will assure that the prescriber or therapy order at least ir more frequently if ary based on the nursing	01970			
02040 SS=F	An assisted living far has a secured dem requirements of sect following additional (1) a hazard vulnerarisk must be performed property. The hazard assessment must be protect the resident (2) the facility shall approved supervise by August 1, 2029.  This MN Requirement by: Based on record relicensee failed to prassessment or hazard of the physical environment.	acility with dementia care that entia care unit must meet the ction 144G.45 and the requirements: ability assessment or safety med on and around the rds indicated on the re assessed and mitigated to s from harm; and be protected throughout by an ed automatic sprinkler system ent is not met as evidenced view and interview, the	02040			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
IRIS PARK COMMONS			STATE, ZIP CODE ENUE WEST 04			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02040	This practice results violation that did no safety but had the president's health or widespread scope (or represent a system or has the potential of the residents).  Findings include:  On May 30, 2023, a records were provide reviewed by survey between 1:30 p.m. hazard vulnerability environment on and mitigation factors with documentation provides of the residents.	ility to affect all staff, ors.  ed in a level two violation (a tharm a resident's health or otential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all approximately 1:30 p.m., led for review. Records were staff on May 30, 2023, and 2:15 p.m. A safety risk or assessment of the physical diaround the property with as not included in the vided.  at approximately 2:20 p.m., ving director (LALD)-A verified	02040			
02110 SS=F	(a) In addition to the required in the licentassisted living facility must develop and in procedures that add (1) philosophy of hor	e policies and procedures sing of all facilities, the ty with dementia care licensee mplement policies and	02110			

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PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
IRIS PARK COMMONS  1850 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  1850 UNIVERSITY AVENUE WEST SAINT PAUL, MN 55104  ID PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY)			23247	B. WING		06/0	1/2023
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SAINT PAUL, MN 55104  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SAINT PAUL, MN 55104  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY)	NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IRIS PARK	COMMONS					
02110 Continued From page 39	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement the required policies and procedures for assisted living with dementia care (ALFDC), and ensure the policies were provided to residents or the resident's legal and for designated representative at the time of move-in for three of three residents (R1, R2, R3).		values, mission, and person-centered cashall be implemented (2) evaluation of bed design of supports of including nonpharm person-centered and (3) wandering and exprovides detailed in a resident elopes; (4) medication man assessment of resident elopes; (5) staff training specifications; (5) staff training specifications; (6) description of life (8) limiting the use of the following and from outside medication drills on (9) transportation contents and the designated represed move-in.  This MN Requirementation of the contents and the designated represed move-in.  This MN Requirementation contents and the designated represed move-in.	d promotion of the and how the philosophy ed; havioral symptoms and for intervention plans, hacological practices that are ad evidence-informed; egress prevention that structions to staff in the event agement, including an dents for the use and effects uding psychotropic ecific to dementia care; e enrichment programs and implemented; mily support programs and family engaged; of public address and for emergencies and ly; coordination and assistance to redical appointments; and for esidents' possessions. If procedures must be provided to residents' legal and intatives at the time of the and record review, the evelop and implement the ad procedures for assisted a care (ALFDC), and ensure to ovided to residents or the lor of designated representative	02110			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNI\		STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
TAG	This practice results violation that did no safety but had the president's health or widespread scope (or represent a system or has the potential of the residents).  The findings included the findings included the residents.  The licensee had a effective August 1, 2.  The licensee lacked required for a provice 1) philosophy of how upon the assisted limits in and how the philosom (2) evaluation of be of supports for internon-pharmacologic person-centered and (3) wandering and expression and provides detailed in a resident elopes; (4) medication man assessment of resident elopes; (5) staff training specific persons the provides detailed in a resident elopes; (5) staff training specific persons the provides detailed in a resident elopes; (5) staff training specific persons the provides detailed in a resident elopes; (6) staff training specific persons the provides detailed in a resident elopes; (6) staff training specific persons the provides detailed in a resident elopes; (7) medications, inclined the provides detailed in a resident elopes; (8) staff training specific persons the provides detailed in a resident elopes; (9) staff training specific persons the provides detailed in a resident elopes; (9) staff training specific persons the provides detailed in a resident elopes; (1) staff training specific persons the provides detailed in a resident elopes; (1) staff training specific persons the provides detailed in a resident elopes; (1) staff training specific persons the provides detailed in a resident elopes; (1) staff training specific persons the provides detailed in a resident elopes; (1) staff training specific persons the provides detailed in a resident elopes; (1) staff training specific persons the provides detailed in a resident elopes; (1) staff training specific persons the provides detailed in a resident elopes; (2) staff training specific persons the provides detailed in a resident elopes; (2) staff training specific persons the provides detailed in a resident elopes; (2) staff training elopes the p	ge 40  ed in a level two violation (a tharm a resident's health or otential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all experience are provided based wing facility licensee's values, otion of person-centered care ophy shall be implemented; havioral symptoms and design vention plans, including all practices that are and evidence-informed; egress prevention that structions to staff in the event agement, including an dents for the use and effects uding psychotropic ecific to dementia care; e enrichment programs and	02110		PRIATE	DATE
	<ul><li>(7) description of fa</li><li>efforts to keep the f</li><li>(8) limiting the use</li></ul>	mily support programs and amily engaged; of public address and or emergencies and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	23247	B. WING		06/0	1/2023
NAME OF PROVIDER OR SUPPLIER IRIS PARK COMMONS	1850 UNIV	PRESS, CITY, S ERSITY AVE			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES SUST BE PRECEDED BY FULL SIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
and from outside med (10) safekeeping of re (10) safekeeping of re R1 was admitted Sepreceiving assisted livi 2021.  R1's service plan, data indicated R1 had diagand dysphagia, and reasistance with activity meals, medication mastockings, toileting, he R2 was admitted Nov receiving assisted livi 2021.  R2's service plan, data indicated R2 had diaga diabetes mellitus, prodepression, and received assistance with medical glucose (BG) monitor housekeeping, and lata R3 was admitted Decidiagnoses including of R3's service plan, data R3 received services ADLs, meals, medical housekeeping, and lata R1, R2, and R3's resi August 22, 2018, Oct December 6, 2022, respecial Care for Alzhorest R1 was admitted Care for Alzhorest R2 was admitted R3 received services ADLs, meals, medical housekeeping, and lata R1, R2, and R3's resi August 22, 2018, Oct December 6, 2022, respecial Care for Alzhorest R2 was admitted Care for Alzhorest R2 was admitted December 6, 2022, respecial Care for Alzhorest R2 was admitted Care for Alzhorest R3 was admitted December 6, 2022, respecial Care for Alzhorest R3 was admitted Care for Alzhorest R4 was admitted December 6, 2022, respecial Care for Alzhorest R4 was admitted Care for Alzhorest R4 was admitted S4 was admitted December 6, 2022, respecial Care for Alzhorest R4 was admitted S4 was admitted S4 was admitted December 6, 2022, respecial Care for Alzhorest R4 was admitted S4 was adm	ordination and assistance to dical appointments; and esidents' possessions.  Interest 10, 2018, and beganing services on August 1,  Ited February 14, 2022, gnoses including demential eceived services including ties of daily living (ADLs), anagement, compression ousekeeping, and laundry.  Ited November 15, 2021, gnoses including type 2 postate cancer, and major ived services including cation management, blooding, catheter care, aundry.  Ited April 3, 2022, and had dementia.  Ited April 3, 2023, indicated including assistance with atton management, aundry.  Ited April 3, 2023, indicated including assistance with atton management, aundry.  Ited April 3, 2023, indicated including assistance with atton management, aundry.	02110			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	23247	B. WING		06/0	1/2023
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00.0	
IRIS PARK COMMONS		ERSITY AVE	ENUE WEST 04		
OVANID CLIMMADV CTAT		,		<b>2</b> N1	()/5)
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
02110 Continued From pag	je 42	02110			
lacked descriptions of evaluation of behave supports for intervent non-pharmacological person-centered and wandering and egred detailed instructions resident elopes; -medication manage assessment of reside of medications, inclusive medications; -limiting the use of posystems for emerger only; -transportation coord and from outside measafekeeping of reside of medications.  On June 1, 2023, at living director (LALD) updated policies, and policies. LALD-A furt updated policies. LA not have specific derprovided information have some additional packet.  -at 4:45 p.m., LALD-additional demential provided, which were Disclosure Requirements (the pupdated to reflect curved.)	of the following: rioral symptoms and design of ntion plans, including al practices that are d evidence-informed; ess prevention that provides to staff in the event a  ement, including an ents for the use and effects ading psychotropic  bublic address and intercom ncies and evacuation drills  dination and assistance to edical appointments; and dents' possessions.  12:04 p.m., licensed assisted b)-A stated they have no d corporate did not provide ther stated she was buying LD-A further stated they did mentia care policies, but in the contract, and might al information in the welcome  A stated she did not have care policies beyond the 2 e related to Dementia nents and Staff Training policies provided were not urrent statutory requirements).	02110			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER			STATE, ZIP CODE ENUE WEST		
II (IO I AI)	ar oominion	SAINT PA	UL, MN 551	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	Continued From pa	ge <b>4</b> 3	02310			
02310 SS=G		) Appropriate care and	02310			
	living services that a resident's needs an	the right to care and assisted are appropriate based on the d according to an up-to-date to accepted health care				
	by: Based on observation review, the licenses services according medical or nursing residents (R3) who bed rail). This result order issued on Mail In addition, the licer	ent is not met as evidenced on, interview, and record failed to provide care and to acceptable health care, standards for one of two utilized grab bars (consumer ted in an immediate correction y 31, 2023, at 6:10 p.m. usee failed to ensure proper gen (O2) tanks for one of one				
	violation that harmed not including serious or a violation that has serious injury, impairs a limited number of real limited number of a limited number of	ed in a level three violation (a ed a resident's health or safety, injury, impairment, or death, as the potential to lead to irment, or death) and was discope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	of grab bars (consu	documented evidence the use mer bed rails) was identified sk of entrapment and falls, nited to, proper installation				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNI\	,	STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	recall and education using the bed rail do R3 was admitted Do diagnoses including infection, and osteo dated April 3, 2023, services including a management, bathi (ADLs), meals, hou R3's individual abust comprehensive ass 2023, indicated R3 positioning devices. On May 31, 2023, a observation of care have a consumer-sinear the head of the white U-shaped bar wide with a horizont between the mattre secured to the fram The right side rail which be wide with a horizont between the mattre secured to the fram The right side rail which wide with a horizont between the mattre secured to the fram The right side rail which wide with 2 inches wide with 3 inches wide wide with 3 inches wide with 3 inches wide with 3 inc	acturer guidelines, check for a on the risk and benefits of evice.  ecember 29, 2022, and had a dementia, urinary tract porosis. Their service plan indicated R3 received essistance with medication and, activities of daily living sekeeping, and laundry.  se prevention plan (IAPP) and essment, both dated April 27, did not "have side rails/bed" or bed mobility devices.  at 8:33 a.m., during an es, R3's bed was observed to the bed rail on both sides es bed. The left side rail was a est and bed frame, and e with a safety retention strap. The as a gray U-shaped bar with a she top, approximately 16 norizontal cross-bars, the mattress and bed frame, the a safety retention strap.  at 8:50 a.m., unlicensed estated R3 just moved in a few as had the grab bars on the ed in. ULP-G stated staff were bed rail was in the "up" dent was in bed, but did not begarding "grab bars"	02310			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
		23247	B. WING		06/0	1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
IDIO DA E	N/ COMMONO	1850 UNI\	/ERSITY AVE	ENUE WEST		
IRIS PARK COMMONS SAINT F			UL, MN 5510	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
02310	Continued From pa	ge <b>45</b>	02310			
	not remember talking about the risks of use had not mentioned today. R3 further stalking the risks of use her to sit up and more					
	(RN)-C stated they education regarding consumer bed rails not checked the bed they audited the factors, but that was determined.	had not provided any risks associated with the for R3 or their family, and had rails for recalls. RN-C stated cility for bed rails and grab one before R3 moved in and they were not aware the ent on R3's bed.				
	stated R3's bed rails time she moved into 2022. F-H further st discussions regardithat time, but could she was not sure of	t 4:05 p.m., R3's family (F)-H s were added to her bed at the the facility in December ated they might have hading the risks of the bed rails at not say for sure. F-H stated the manufacturer of the two look for that information.				
	Guide to Bed Safety April 2010, indicated bed rails are used, assessment of the partition o	Administration's (FDA) A y, dated 2000, and revised d following information: "When perform an on-going patient's physical and mental tor high-risk patients. The "Patients [residents] who memory, sleeping, uncontrolled body movement, ed and walk unsafely without e carefully assessed for the hem from harm, such as by the patient's health care termine how best to keep the				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
IDIO DA E				ENUE WEST		
IRIS PAR	RK COMMONS	SAINT PA	UL, MN 551	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
	Continued From partient safe."  The licensee's Side policy dated August alert the RN or licer [resident] has any ty equipment and the will then evaluate who be safe for the client professional will edure presentative and/risks related to side rail does not appear RN or licensed profethe client, the client involved family menter removed and will reto reduce the risk of licensed professions conversations and references and Free (FAQ) regarding conversations and references	Rail Safety Assessment 28, 2020, indicated, "Staff will used professional if a client ype of side rail or similar RN or licensed professional hether the side rail appears to it. The RN or licensed ucate the client, the client's or family members about the rails, and if the client's side r to meet FDA standards, the ressional will recommend to ressional will recommend to respresentative, the client's ribers that the side rail be commend alternative options f a fall out of bed. The RN or al will document these recommendations."  The licensee must al's cognitive and physical in to the bed rail to determine the for the bed rail and whether the risk for entrapment or falls" of tified licensee must ensure were securely attached and vidual manufacturer's	02310	DEFICIENCY)		
		as been educated on the risk				

Minnesota Department of Health

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Minnesota Department of Health

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		23247	B. WING		06/01/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IRIS PAR	RK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
02310	Continued From page	ge <b>4</b> 7	02310			
	entrapment." Additional have a process in punicensed personn nurse assessment." family. The FAQ furunable to locate material are unable to assess portable bed rail is linstalled properly. The property of th					
	An immediate correction May 31, 2023, at 6: 7:00 p.m., the immediate	CORRECTION: Immediate ction order was issued on 10 p.m. On June 1, 2023, at ediacy of the order was lifted. I remained at a 3/G.				
		E eptember 10, 2018, and began ving services on August 1,				
	indicated R1 receive assistance with acti meals, medication r	ated February 14, 2022, ed services including vities of daily living (ADLs), management, compression housekeeping, and laundry.				
	21, 2023, by RN-C, needed (PRN) via a machine that produfurther indicated R1	dition assessment, dated April indicated R1 used O2 as in O2 concentrator (a tankless ces O2). The assessment had portable O2 tanks for eded assistance with refilling				

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Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER	1850 UNI\	, ,	STATE, ZIP CODE ENUE WEST 04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
02310	Continued From pa	ge 48 it 9:22 a.m., R1's room was	02310			
	observed to have 3 near a window, and tipping. A portable 0 observed sitting ato equipment was plug	O2 tanks sitting on the floor not secured to prevent O2 tank filling device was op an O2 concentrator. The gged in, but not turned on, had and appeared unused.				
	had portable O2 tar after she was hospi stated staff were tra trained to be sure the were used for a res	It 10:08 a.m., ULP-I stated R1 lks delivered to the facility talized in April 2023. ULP-I sined on filling O2 tanks, and he correct tank and flow rate ident using O2. ULP-I was not be requirements for O2 tanks.				
	had PRN O2 ordered hospital, but had no further stated she w	at 10:38 a.m., RN-C stated R1 and after returning from the at needed to use it. RN-C as not aware there were stored in R1's room.				
	Oxygen Cylinder Ston the National Fire Standard 99 (NFPA Code), dated April 1 of hazards associated 1) General fires and oxygen-rich atmosp 2) Mechanical problemage to compress guidance further incompress guidance further guidance further incompress guidance further incompress guidance further incompress guidance further guidance further guidance guidance further guidance g	d explosions enhanced by heres lems such as physical seed gas cylinders. The dicated, "when storing up to of oxygen, cylinders must be racks) to prevent them from				
		cal's "Customer Info Booklet" ed, "Small [oxygen] cylinders				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		23247	B. WING		06/0	1/2023
	PROVIDER OR SUPPLIER			STATE, ZIP CODE ENUE WEST		
IRIS PAR	K COMMONS	SAINT PA	UL, MN 551	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (PROVIDENCY)	D BE	(X5) COMPLETE DATE
02310	Continued From pa	ge 49	02310			
	should be in a rack necessary, they car	anding up if possible, but or box to prevent falling. If he stored in a lying down so that they do not roll or zard."				
	No further informati	on was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
03090 SS=C	144.6502, Subd. 8 I	Notice to Visitors	03090			
	entrance accessible "Electronic monitori cameras and audio record persons and (b) The facility is res	ost a sign at each facility to visitors that states: ng devices, including security devices, may be present to activities." sponsible for installing and hage required in this				
	by: Based on observation failed to ensure the the main entry way statutory language to monitoring activity,	ent is not met as evidenced on and interview, the licensee required notice was posted at of the facility, including to disclose electronic potentially affecting all current isted living facility, staff, and acility.				
	violation that has not a minimal impact or affect health or safe widespread scope (or represent a system)	ed in a level one violation (a of potential to cause more than the resident and does not ety), and was issued at a when problems are pervasive emic failure that has affected affect a large portion or all of				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>`</b>	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		23247	B. WING		06/01/2023
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
IRIS PAF	RK COMMONS		/ERSITY AVI UL, MN 551	ENUE WEST 04	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
03090	Continued From pa	ge 50	03090		
	the residents).				
	The findings include	e:			
	the facility with register entrance to the facility verbatim notice to verbatim notice to verbatim notice to verbatim notice of required posting, but notice yet.  The licensee's Elect August 24, 2020, in post a sign at each visitors that states, including security care.	R CORRECTION:			

Minnesota Department of Health



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

Type: Full

Date: 05/31/23
Time: 11:11:50
Report: 1021231149

## Food and Beverage Establishment Inspection Report

Page 1

–Location:

Iris Park Commons

1850 University Avenue West

St Paul, MN55104 Ramsey County, 62

**License Categories:** 

Expires on: //

Establishment Info:

ID#: 0038957

Risk:

Announced Inspection: Yes

Operator:

Phone #: 6516461026

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.

EGG SALAD (45F), CHICKEN SOUP (46F) FOUND IN THE IPC KITCHEN TRAULSEN TWO DOOR COOLER AND HALF & HALF (45F), MILK (46F), AND CHOCOLATE PUDDING (50F) FOUND IN THE MEMORY CARE REFRIGERATOR MEASURED ABOVE 41F. SEE COMMENTS.

Comply By: 05/31/23

#### 3-500A Microbial Control: cooling

3-501.15B

\*\* Priority 2 \*\*

MN Rule 4626.0390B Loosely cover containers of cooling food and arrange in cold holding equipment in a manner to maximize heat transfer through the container walls.

CHICKEN SOUP IN THE TRAULSEN TWO DOOR COOLER WAS FOUND FULLY COVERED AND THE PLASTIC WRAP HAD CONDENSATION ON THE TOP INSIDE. ALLOW FOOD TO COOL BEFORE COVERING. SOUP WAS OUT OF TEMPERATURE AND WAS DISCARDED DURING INSPECTION.

Comply By: 05/31/23

### 4-300 Equipment Numbers and Capacities

4-302.13B

\*\* Priority 2 \*\*

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN THE MEMORY CARE HIGH TEMPERATURE DISH

Type: Full
Date: 05/31/23
Time: 11:11:50
Report: 1021231149

Iris Park Commons

# Food and Beverage Establishment Inspection Report

MACHINE. PROVIDE. Comply By: 06/07/23

## 2-100 Supervision

#### 2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

THE CERTIFIED FOOD PROTECTION MANAGER (CFPM) CERTIFICATE WAS NOT FOUND ON-SITE. ABLE TO VERIFY THAT THE CHEF MICHAEL PATTERSON HAS A CURRENT CFPM CERTIFICATE. COMPLY WITH RULE ABOVE.

Comply By: 06/07/23

## Surface and Equipment Sanitizers

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit

Location: SANI BUCKET, IPC KITCHEN

Violation Issued: No

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit

Location: SANI DISPENSER

Violation Issued: No

Final Utensil Surface Temp: = at 166 Degrees Fahrenheit

Location: MEMORY CARE DISH MACHINE

Violation Issued: No

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit

Location: SANI BUCKET, MEMORY CARE

Violation Issued: No

#### Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 45 Degrees Fahrenheit - Location: EGG SALAD - TRAULSEN TWO DOOR COOLER

\*DISCARDED

Violation Issued: Yes

Process/Item: Cold Holding

Temperature: 46 Degrees Fahrenheit - Location: CHICKEN SOUP - TRAULSEN TWO DOOR COOLER

\*DISCARDED

Violation Issued: Yes

Process/Item: Cold Holding

Temperature: 39 Degrees Fahrenheit - Location: CUT MELON - TRAULSEN TWO DOOR COOLER

Violation Issued: No

Process/Item: Cooling

Temperature: 50 Degrees Fahrenheit - Location: YOGURT - TRAULSEN TWO DOOR COOLER,

COOLING FROM AMBIENT FOR 1 HOUR

Violation Issued: No

Type: Full
Date: 05/31/23
Time: 11:11:50
Report: 1021231149

Iris Park Commons

## Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: HARD BOILED EGGS - TRAULSEN TWO DOOR

**COOLER** 

Violation Issued: No

Process/Item: Cooking

Temperature: 191 Degrees Fahrenheit - Location: GROUND BEEF - STOVE

Violation Issued: No

Process/Item: Hot Holding

Temperature: 178 Degrees Fahrenheit - Location: CHICKEN - HOT WELLS

Violation Issued: No

Process/Item: Hot Holding

Temperature: 169 Degrees Fahrenheit - Location: RICE - HOT WELLS

Violation Issued: No

Process/Item: Hot Holding

Temperature: 159 Degrees Fahrenheit - Location: EGG ROLLS - HOT WELLS

Violation Issued: No

Process/Item: Cold Holding

Temperature: 37 Degrees Fahrenheit - Location: COLESLAW - COLD WELLS

Violation Issued: No

Process/Item: Cold Holding

Temperature: 36 Degrees Fahrenheit - Location: PASTA SALAD - COLD WELLS

Violation Issued: No

Process/Item: Cold Holding

Temperature: 40 Degrees Fahrenheit - Location: CUT MELON - COLD WELLS

Violation Issued: No

Process/Item: Cold Holding

Temperature: 45 Degrees Fahrenheit - Location: HALF & HALF - MEMORY CARE REFRIGERATOR

Violation Issued: Yes

Process/Item: Cold Holding

Temperature: 46 Degrees Fahrenheit - Location: MILK - MEMORY CARE REFRIGERATOR

Violation Issued: Yes

Process/Item: Cold Holding

Temperature: 50 Degrees Fahrenheit - Location: CHOCOLATE PUDDING - MEMORY CARE

REFRIGERATOR
Violation Issued: Yes

Total Orders In This Report Priority 1 Priority 2 Priority 3

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH DIRECTOR OF DINING OPERATIONS, ROBERT JONES AND IPC DIRECTOR/LALD, DEBORAH ASHAMU.

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

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Type: Full
Date: 05/31/23
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Report: 1021231149

Iris Park Commons

# Food and Beverage Establishment Inspection Report

THE EGG SALAD AND THE CHICKEN SOUP WERE FROM YESTERDAY AND STAFF DISCARDED BOTH TCS FOOD ITEMS DURING INSPECTION.

DIRECTOR ADJUSTED THE TEMPERATURE OF THE MEMORY CARE REFRIGERATOR. UNABLE TO VERIFY IF THE ITEMS WERE TAKEN OUT OF THE REFRIGERATOR FOR BREAKFAST. THE AMBIENT TEMPERATURE OF THE MEMORY CARE REFRIGERATOR MEASURED BELOW 41F. STAFF WILL MONITOR TCS FOODS.

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 1021231149 of 05/31/23.

Certified Food Protection Manager MICHA	EL J. PATTERSON
Certification Number: FM114297	Expires: 09/21/25
Inspection report reviewed with person in charge and emailed.	
Signed:	Signed: ###
ROBERT JONES	Melissa Ramos
DIRECTOR OF DINING	Environmental Health Specialist
OPERATIONS	Metro District Office
	651-201-4495
	Melissa Ramos@state mn us