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

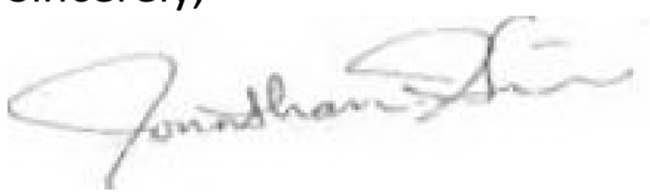
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for 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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23247015-1 On September 26-27, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed June 1, 2023. At the time of the survey, there were 58 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated September 27, 2023, for the specific Minnesota Food Code deficiencies.	{0 480}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	{0 680}		

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{0 680}	Continued From page 2 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No Further Action Needed	{0 680}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but	{0 780}		

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{0 780}	Continued From page 3 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No Further Action Needed	{0 780}		
{0 800} SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No Further Action Needed	{0 800}		
{0 900} SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.	{0 900}		

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{0 900}	Continued From page 4 (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: No Further Action Needed	{0 900}		
{0 970} SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or	{0 970}		

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{0 970}	Continued From page 5 unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No Further Action Needed	{0 970}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human	{01470}		

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{01470}	Continued From page 6 Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No Further Action Needed	{01470}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	{01500}		

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{01500}	Continued From page 7 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	{01500}		

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{01500}	Continued From page 8 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No Further Action Needed	{01500}		
{01540} SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01540}		

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{01540}	Continued From page 9 No Further Action Needed	{01540}		
{01830} SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: No Further Action Needed	{01830}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications 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	{01880}		
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders 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.	{01970}		

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{01970}	Continued From page 10 This MN Requirement is not met as evidenced by: No Further Action Needed	{01970}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment 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	{02040}		
{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: (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	{02110}		

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{02110}	Continued From page 11 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: No Further Action Needed	{02110}		
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	{03090}		

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	23247	A. BUILDING: _____ B. WING _____	R 09/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{03090}	Continued From page 12 This MN Requirement is not met as evidenced by: No Further Action Needed	{03090}		

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

Location:
Iris Park Commons
1850 University Avenue West
St Paul, MN55104
Ramsey County, 62

Establishment Info:
ID #: 0038957
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

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
	1	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 Manager: CARRIE L. DUBOIS

Certification Number: FM43547 Expires: 09/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
ROBERT JONES
DIRECTOR OF DINING

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us

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

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).

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23247	A. BUILDING: _____ B. WING _____	06/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23247015 On May 30, 2023, through June 1, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 56 active residents; 30 receiving services under the Assisted Living with Dementia Care license. An immediate correction order was issued for 2310 on May 31, 2023, at 6:10 p.m. On June 1, 2023, at 7:00 p.m., the immediacy of the order was lifted. The scope and level remained the same.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care license providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated May 31, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510		

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0 510	Continued From page 2 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure proper cleaning and disinfection of a glucometer. Further, the licensee failed to ensure direct care staff appropriately gloved and performed hand hygiene (HH) for 2 of 3 staff (unlicensed personnel (ULP)-G, ULP-K). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 had diagnoses including type 2 diabetes, depression and high blood pressure. R2's service plan dated May 31, 2023, indicated, "Resident has [methicillin-resistant staphylococcus aureus (MRSA)-an antibiotic resistant bacteria] and is on precautions.	0 510		

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0 510	Continued From page 3 ALWAYS wear [personal protective equipment (PPE)] (gown, gloves, mask, face shield) when assisting with catheter or urine." On May 30, 2023, at 2:42 p.m., clinical nurse supervisor (CNS)-B stated R2 had PPE available in a cart outside his room because he had MRSA in his urine. CNS-B stated staff could wear PPE if they chose. HAND HYGIENE/GLOVING ULP-G ULP-G was hired December 7, 2016, and provided direct care services for residents. On May 31, 2023, from 8:12 a.m. to 9:14 a.m., ULP- G was observed providing cares for residents. -at 8:12 a.m., ULP-G donned gloves, knocked, and opened the door to R2's room. Before entering, ULP-G donned a second pair of gloves, shoe covers, a gown, and face shield. ULP stated they were instructed to wear PPE whenever dealing with R2's urine. ULP-G removed a soiled split-gauze dressing from R2's suprapubic catheter (a catheter inserted through the abdomen into the bladder to drain urine). ULP-G cleansed the catheter tubing and surrounding skin with an alcohol (ETOH) preparation (prep) pad. Without changing gloves, ULP-G applied a clean gauze dressing and secured it in place with medical tape. Wearing soiled gloves, ULP-G searched through a box of wrapped, catheter supplies stored in R2's closet. ULP-G opened a package, removing a catheter bag and tubing kit, and removed a protective cap from the tubing end. R2 refused to allow ULP-G to change the catheter bag and tubing, so ULP-G replaced the cap, and returned the opened bag and tubing into	0 510		

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0 510	Continued From page 4 the box of supplies. ULP-G emptied urine from R2's catheter bag into a graduate, emptied and rinsed the graduate, disposed of garbage and doffed one pair of gloves, leaving a second pair of gloves in place. ULP-G then exited R2's room, doffed PPE including gloves, and appropriately performed HH. -at 8:33 a.m., ULP-G donned gloves, knocked and entered R3's room. ULP-G assisted R3 to the bathroom, and removed R3's brief. ULP-G removed gloves, and donned a new pair of gloves. ULP-G assisted R3 to dress and wash her face. R3 performed peri care independently and asked for privacy. ULP-G removed gloves, exited R3's room, and without performing HH, proceeded, with a wheeled cart, to the elevator and down to the first floor dining room to get breakfast for R3. ULP-G donned gloves, ordered food for R3, retrieved juice from a dispenser, doffed gloves, received meal tray from server, and placed it on the cart. ULP-G returned to R3's room. -at 8:55 a.m., ULP-G donned gloves and administered medications to R3, including applying a topical medication to R3's back and neck. ULP-G doffed gloves, donned one glove to left hand, documented medications administered, donned one glove to right hand, carried garbage to the garbage room, and removed both gloves. No HH was observed. -at 9:14 a.m., without performing HH, ULP-G donned gloves, knocked and entered R7's room. ULP-G stated next she would give R7 a shower. ULP-K ULP-K was hired August 18, 2017, and provided direct care services for residents. On June 1, 2023, at 10:49 a.m., ULP-K assisted R2 check his blood glucose (BG) level. ULP-K	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 510	Continued From page 5 donned PPE, including two pair of gloves, mask, gown, and shoe covers. ULP-K knocked and entered R2's room, and accessed R2's electronic medical record (EMR). ULP-K unzipped a pouch containing a glucometer and assisted R2 to check his BG level, using the glucometer, then removed one pair of gloves, exposing an additional pair of gloves on underneath. ULP-K returned the glucometer to to the pouch and zipped it closed. ULP-K removed gloves, exposing a third pair of gloves on underneath. ULP-K exited R2's room, removed PPE and gloves. ULP-K then performed HH appropriately. -at 11:16 a.m., ULP-K stated she received HH training and was taught it was ok to wear two or three pair of gloves during cares. GLUCOMETER CLEANING On May 31, 2023, at 11:19 a.m., ULP-G was observed to assist R2 check his BG level. After checking R2's BG level, ULP-G zipped the glucometer into a pouch and placed it on a wheeled cart. ULP-G did not clean the glucometer. On May 31, 2023, at 11:30 a.m., ULP-G stated she used "purple top wipes" (sani-wipes-a germicidal disposable wipe) to clean R2's glucometer at the start of her shift. ULP-G stated she was not taught how or when she should clean the glucometer. On May 31, 2023, at 11:46 a.m., registered nurse (RN)-B stated they had not implemented a glucometer cleaning schedule in the facility. On June 1, 2023, at 10:49 a.m., ULP-K assisted R2 check his blood glucose (BG) level. After she completed the BG level check, ULP-K zipped the	0 510		

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0 510	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 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		

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0 510	Continued From page 7 The licensee's Hand Washing/Hand Hygiene policy, reviewed August 29, 2020, indicated, "Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water. Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns e. Before eating, handling food or assisting a client with meals f. Before and after assisting a client with personal cares (e.g., oral care, bathing) g. Before and after assisting a client with toileting/peri care (hand washing with soap and water) h. When hands are visibly soiled (hand washing with soap and water) i. Before and after performing any invasive procedures (e.g., fingerstick blood sampling) J. After personal use of the toilet (hand washing with soap and water) k. After performing your personal hygiene". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 8 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. Further, the licensee failed to post an emergency disaster plan prominently. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23247	A. BUILDING: _____ B. WING _____	06/01/2023

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0 680	Continued From page 9 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 30, 2023, at 12:02 p.m., the facility front entrance area and a posting area located by the first floor, white elevator were observed. Both areas lacked a posted emergency disaster plan. The [licensee] All Hazards Plan, dated May 31, 2021, lacked documentation of annual review, and customization to the facility and resident-specific individualization including the following: - a risk assessment considering all hazards that may impact all or a portion of the facility; - an assessment of the at risk population's needs; and - a communication plan that included names and contact information for staff, resident physicians, other facilities. On June 1, 2023, at 6:30 p.m., licensed assisted living director (LALD)-A stated she understood that the emergency preparedness plan be reviewed annually, and stated it made sense the plan would need to be customized for the location related to specific hazards, and specific responses including the acuity level and emergency contact information for residents and plan with information for communicating with staff. The licensee's [Licensee] All Hazards Plan dated May 31, 2021, indicated, "[Licensee] shall maintain a comprehensive Emergency Plan, which incorporates an Incident Command System	0 680		

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0 680	Continued From page 10 (ICS). Emergency management guidelines shall be developed and made widely available to all staff. The plan will address the major components required for a successful Emergency Plan. The plan will include the essential components of risk mitigation, emergency preparedness, emergency response; recovery and also education. The plan shall be maintained in accordance with state and federal regulations." The plan further indicated, "All emergency policies are reviewed and approved at least annually. " No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to	0 780		

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0 780	Continued From page 11 operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On May 30, 2023, between 11:00 a.m. and 1:30 p.m., survey staff toured the facility with director of maintenance (DM)-D, licensed assisted living director (LALD)-A, and maintenance supervisor (MS)-E. During the facility tour, survey staff observed the following: 1. Smoke alarms were not installed in the sleeping rooms of resident apartments 109, 113, 201, 213, and 309. 2. A smoke alarm was not installed outside the sleeping area in the immediate vicinity of the bedroom in resident apartment 310. 3. In unit 302, the smoke alarms did not test as	0 780		

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0 780	Continued From page 12 interconnected so that actuation of one alarm caused all alarms in the dwelling unit to operate. These deficient conditions were verified by DM-D, LALD-A, and MS-E, accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	0 800		

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0 800	Continued From page 13 of staff are involved, or the situation has occurred only occasionally). Findings include: On May 30, 2023, between 11:00 a.m. and 1:30 p.m., survey staff toured the facility with director of maintenance (DM)-D, licensed assisted living director (LALD)-A, and maintenance supervisor (MS)-E. During the facility tour, in resident apartment 219, survey staff observed that the bedroom smoke alarm did not provide an audible alarm when tested by DM-D. This deficient condition was verified by DM-D, LALD-A, and MS-E, accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract	0 900		

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0 900	Continued From page 14 and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 was admitted September 10, 2018, and began receiving assisted living services on August 1, 2021. R1's service plan, dated February 14, 2022,	0 900		

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0 900	Continued From page 15 indicated R1 received services including assistance with activities of daily living (ADLs), meals, medication management, compression stockings, toileting, housekeeping, and laundry. R2 was admitted November 2, 2020, and began receiving assisted living services on August 1, 2021. R2's service plan, dated November 15, 2021, indicated R2 received services including assistance with medication management, blood glucose (BG) monitoring, catheter care, housekeeping, and laundry. R1, and R2's record included an assisted living contract, titled Residency Agreement, signed August 22, 2018, and October 1, 2020, respectively. The records lacked documentation the resident or their representative received an updated assisted living contract after August 1, 2021, including the following: - in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility; - the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: the licensee of the facility; the managing agent of the facility, if applicable; and the authorized agent for the facility. - a disclosure of the category of assisted living facility license held by the facility; and - the right under section 144G.54 to appeal the termination of an assisted living contract. On June 1, 2023, at 12:04 p.m., licensed assisted living director (LALD)-A stated the contract was updated in 2021, and was sent out to all residents	0 900		

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0 900	Continued From page 16 or their representative, but they had not received signed documentation for R1 and R2. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 970		

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0 970	Continued From page 17 R1 was admitted September 10, 2018, and began receiving assisted living services on August 1, 2021. R1's service plan, dated February 14, 2022, indicated R1 received services including assistance with activities of daily living (ADLs), meals, medication management, compression stockings, toileting, housekeeping, and laundry. R2 was admitted November 2, 2020, and began receiving assisted living services on August 1, 2021. R2's service plan, dated November 15, 2021, indicated R2 received services including assistance with medication management, blood glucose (BG) monitoring, catheter care, housekeeping, and laundry. R3 was admitted December 29, 2022. R3's service plan, dated April 3, 2023, indicated R3 received services including assistance with activities of daily living (ADLs), meals, medication management, housekeeping, and laundry. R1, R2, and R3's record included an assisted living contract, titled Residency Agreement, signed August 22, 2018, October 1, 2020, and December 6, 2022, respectively. The contract included the following language in the contract, indicating a waiver of liability: Section 9 - NO LIABILITY OF MANAGEMENT a. Personal Property of Resident; No Liability of Management "Management has no responsibility to Resident or any third party for any personal property placed in the Apartment or any other location within [facility]	0 970		

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0 970	Continued From page 18 or its grounds by Resident or the owner of such personal property. Management is not responsible to Resident or any third party for loss of any personal property by theft or any other cause. Resident assumes all risks for harm to or loss of any of Resident's personal property, and release, indemnify, defend, and hold Management harmless from any and all liability with respect to harm to or loss of any of Resident's personal property." On June 1, 2023, at 12:04 p.m., licensed assisted living director (LALD)-A stated the contract was updated in 2021, and was sent out to all residents or their representative, but they had not received signed documentation for R1 and R2. On June 1, 2023, at 12:51 p.m., LALD-A stated they would need to look further at the waivers of liability in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section	01470		

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01470	Continued From page 19 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01470		

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01470	Continued From page 20 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living, including all required content, for two of two employees (registered nurse (RN)-C, unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-C RN-C was hired August 21, 2021, and provided direct care and assessment services for residents of the facility. RN-C's employee record lacked documentation the following orientation topics were completed: -an overview of assisted living MN statutes 144G; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	01470		

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01470	Continued From page 21 -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services. ULP-F ULP-F was hired February 26, 2021, and began providing direct care services under the licensees Assisted Living with Dementia Care license on August 1, 2021. On May 31, 2023, at 1:12 p.m., ULP-F was observed to assist R6 with toileting. ULP-F's employee record lacked documentation the following orientation topics were completed: -an overview of assisted living MN statutes 144G; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	01470		

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01470	Continued From page 22 Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On June 1, 2023, at 4:59 p.m. licensed assisted living director (LALD)-A stated as part of the general orientation, staff were assigned the orientation topics, and upon completion of their skills and competencies, they should have completed all orientation requirements. LALD-A stated they would need more reliable way to track completion of required orientation. The licensee's "Home Care Orientation" policy, dated August 28, 2020, was not updated with 144G statutes for assisted living licensure, but indicated orientation would include: "-An overview of Minnesota's home care law (MN Statutes l44A.43 to l44A.4798); -An introduction and review of all of our agency's policies and procedures related to the provision of home care services; -Handling emergencies and use of emergency services; -Reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes 626.556 and 626.557; -The home care bill of rights (MN Statutes l44A.44); -Our program's system for receiving and responding to complaints, where to' report complaints and information on the Office of	01470		

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01470	Continued From page 23 Health Facility Complaints and the Common Entry Point and how clients, staff and others may contact these agencies with complaints; -The consumer advocacy services of the Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, or other relevant advocacy services; and -A review of the types of home care services the employee will be providing and the scope of our agency's license." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500		

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01500	Continued From page 24 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	01500		

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01500	Continued From page 25 Based on observation, interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for two of two employees (registered nurse (RN)-C, unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-C RN-C was hired August 21, 2021, and provided direct care and assessment services for residents of the facility. RN-C's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	01500		

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01500	Continued From page 26 -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-F ULP-F was hired February 26, 2021, and began providing direct care services under the licensees Assisted Living with Dementia Care license on August 1, 2021. On May 31, 2023, at 1:12 p.m., ULP-F was observed to assist R6 with toileting. ULP-F's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topic: -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On May 30, 2023, at 4:04 p.m., licensed assisted living director (LALD)-A stated annual training was assigned through the online training program. On June 1, 2023, at 4:59 p.m., LALD-A stated they would need a more reliable way to track completion of required training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01540	Continued From page 27	01540		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for two of two employees (registered nurse (RN)-C, unlicensed personnel (ULP)-F), with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01540		

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01540	Continued From page 28 The findings include: The licensee had a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2021. RN-C RN-C was hired August 21, 2021, and provided direct care and assessment services for residents of the facility. 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. RN-C's employee record lacked documentation of two hours of dementia care training completed annually. ULP-F ULP-F was hired February 26, 2021, and began providing direct care services under the licensees Assisted Living with Dementia Care license on August 1, 2021. On May 31, 2023, at 1:12 p.m., ULP-F was observed to assist R6 with toileting. ULP-F's employee record included documentation of 0.5 hours of dementia training. The record lacked documentation of completion of 8 hours of dementia care training completed within 80 hours of working including the following topics: -an explanation of Alzheimer's disease and other	01540		

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01540	Continued From page 29 dementia; -problem solving with challenging behaviors; -communication skills; and -principles of person-centered planning and service delivery. ULP-F's employee record included documentation of one hour of annual dementia care training. The record lacked documentation of two hours of dementia care training completed annually. On June 1, 2023, at 4:59 p.m. licensed assisted living director (LALD)-A stated they assigned all the required dementia care training to staff, but would need to complete training record audits to ensure it was done. LALD-A stated they would need more reliable way to track completion of required dementia care training. The licensee's dementia care training policy, dated August 28, 2020, indicated, "Supervisors of direct care staff hired January 1, 2016 or later, will also have at least eight hours of initial training on the topics specified below within 120 working hours of the employment start date." The policy further indicated, "Direct-care staff hired January 1, 2016 or later will complete at least eight hours of initial training on the topics specified below within 160 working hours of the employment start date." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions	01830		

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01830	Continued From page 30 Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted November 2, 2020, and began receiving assisted living services on August 1, 2021. R2 received services including assistance with medication management, blood glucose (BG) monitoring, catheter care, housekeeping, and laundry. On May 31, 2023, at 11:22 a.m., unlicensed personnel (ULP)-G assisted R2 with medication administration. R2's medication administration record (MAR) for May 2023, indicated R2 was administered the following medications daily: -novolog (insulin-for diabetes), 100 units (u)/milliliter (ml);	01830		

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01830	Continued From page 31 -finasteride (for prostate), 5 mg; -furosemide (for water retention), 20 mg; -jardiance (for diabetes), 10 mg; -lantus (insulin-for diabetes), 100 u/ml; -lisinopril (for high blood pressure), 5 mg; -metformin (for diabetes), 500 mg; -myrbetriq (for urinary health), 25 mg; -naltrexone hydrochloride (HCL) (for alcohol dependence), 50 mg; -venlafaxine (for depression), 225 mg; -mirtazapine (for depression), 15 mg; and -tamsulosin (for urinary health) 0.4 mg. R2's record included prescriber orders signed March 17, 2022. The record lacked updated orders signed within 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. On June 1, 2023, at 4:04 p.m., registered nurse (RN)-C stated signed orders needed to be updated every 12 months. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and	01880		

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01880	Continued From page 32 permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure only authorized personnel had access to prescribed medications for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's service plan, dated April 3, 2023, indicated R3 had diagnoses including dementia, hypertension and depression, and received services including assistance with medication management, bathing, meals, housekeeping, and laundry. R3's medication administration record (MAR) for May 2023, indicated R3 was administered the following medications: -amlodipine (for high blood pressure) 2.5 milligrams (mg); -alendronate (for osteoporosis), 70 mg; -acetaminophen (for pain), 1000 mg; -buproprion hydrochloride (HCL) (for depression), 150 mg; -citalopram (for depression), 20 mg; -diclofenac gel (for pain), 2 grams (g); -ibuprofen (for pain), 400 mg; -loratadine (for allergies), 10 mg; -senna (laxative), 8.6 mg;	01880		

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01880	Continued From page 33 -gavilax polyethylene glycol (PEG) powder (for constipation); -tramadol (opioid, for pain), 25 mg; -donepezil (for dementia), 10 mg; -estradiol cream (for urinary tract infection); -latanoprost eye drops (for glaucoma); and -tizanidine (for back pain), 2 mg. On May 31, 2023, at 8:05 a.m., ULP-G was observed assisting residents with cares. ULP-G had a wheeled cart with supplies on it. The surveyor observed a small, white, paper medication cup that contained oral medications, sitting on the cart. ULP-G knocked and looked into R2's room. R2 indicated he was not ready for assistance, so ULP-G went to R3's room. ULP-G knocked and entered R3's room, and closed the door, leaving the cart with the medication cup unattended in the hallway. ULP-G entered R3's bedroom, and attempted to wake R3. R3 refused cares at that time, and stated she wanted to sleep longer. ULP-G returned to the hallway and the cart. -at 8:12 a.m., ULP-G donned personal protective equipment (PPE), knocked, and entered R2's room, closed the door, and left the wheeled cart with the medication cup in the hallway. ULP-G assisted R3 with cares. -at 8:26 a.m., ULP-G returned to the hallway and the cart, and took off PPE. ULP-G walked approximately 100 feet down the hall, leaving the cart outside R2's door. ULP-G entered a hallway bathroom and performed hand hygiene (HH). -at 8:29 a.m., ULP-G returned to the cart with the medication cup sitting on it. -at 8:33 a.m., ULP-G wheeled the cart to R3's room, donned gloves, knocked, and entered with the cart and medication cup. ULP-G assisted R3 with activities of daily living (ADLs) and then exited R3's room with the medication cart, and	01880		

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01880	Continued From page 34 took it to the first floor to get breakfast for R3. ULP-G then returned to R3's room. -at 8:50 a.m., ULP-G stated she already had R3's medications set up in the medication cup on the cart. ULP-G further stated she used the medication administration record (MAR) when preparing the medications, and would document the medications as administered after R3 takes them. ULP-G stated that was the process she usually used for medication administration. -at 8:55 a.m., ULP-G accessed R3's MAR and compared the list to medications in the cup. ULP-G set the medications in front of R3 and left R3's room. The surveyor observed R3 take the medications with water, showing the pills to the surveyor as she took them. The surveyor asked R3 if tramadol was included. R3 replied, "How do I know?" -at 9:04 a.m., ULP-G returned to R3's room and verbalized she had just retrieved tramadol and PEG from the medication cart. ULP-G administered the remaining medications, documented all medications administered, and exited R3's room with the wheeled cart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders 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	01970		

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01970	Continued From page 35 therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 had diagnoses including type 2 diabetes mellitus, neurogenic bladder dysfunction, and major depression. R2's service plan, dated November 13, 2021, indicated R2 received services including assistance with medication management, blood glucose (BG) monitoring, catheter care, housekeeping, and laundry. R2's treatment administration record (TAR) for May 2023 indicated R2 received daily assistance with the following treatments: -blood sugar checks 15-30 minutes before meals and at bedtime; and -dressing change to abdominal supra-pubic area,	01970		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 36 for supra-pubic catheter care. R2's record included prescriber orders signed March 17, 2022, indicating blood sugar checks four times a day, 15-30 minutes before meals and at bedtime. The record further included an incomplete order signed April 5, 2022, which indicated, "Recently got suprapubic catheter needing daily wound dressing" and "OK for home care [registered nurse (RN)] to eval/treat wound (suprapubic)". The record lacked updated orders signed within 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, typically, get signed orders when residents were newly admitted or when orders changed. On June 1, 2023, at 4:04 p.m., registered nurse (RN)-C stated signed orders needed to be updated every 12 months. The licensee's Content of Treatment and Therapy Orders, dated August 29, 2020, indicated, "An order for a treatment or therapy must be dated, signed by the prescriber and must be current and consistent with the client's nursing assessment. The order must contain: a. The client's name; b. Description of the treatment or therapy to be provided; c. The frequency of the treatment or therapy; d. Specific instructions and other information needed to administer the treatment or therapy; e. Any parameter or instructions to 'hold' or modify the therapy, if applicable; f. The prescriber's manual or electronic signature; and	01970		

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	23247	A. BUILDING: _____ B. WING _____	06/01/2023

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01970	Continued From page 37 g. If the prescription is for a PRN treatment or therapy the order must include specific instructions regarding when to administer the treatment or therapy." The policy further indicated, "The RN or Licensed Health Professional will assure that the prescriber renews a treatment or therapy order at least every 12 months, or more frequently if determined necessary based on the nursing assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment 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: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors. This deficient	02040		

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02040	Continued From page 38 practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On May 30, 2023, at approximately 1:30 p.m., records were provided for review. Records were reviewed by survey staff on May 30, 2023, between 1:30 p.m. and 2:15 p.m. A safety risk or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors was not included in the documentation provided. On May 30, 2023, at approximately 2:20 p.m., licensed assisted living director (LALD)-A verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
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: (1) philosophy of how services are provided based upon the assisted living facility licensee's	02110		

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02110	Continued From page 39 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 /or designated representative at the time of move-in for three of three residents (R1, R2, R3).	02110		

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02110	Continued From page 40 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current ALFDC license, effective August 1, 2021. The licensee lacked the following policies required for a provider with an ALFDC license: 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 non-pharmacological 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;	02110		

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02110	Continued From page 41 (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. R1 was admitted September 10, 2018, and began receiving assisted living services on August 1, 2021. R1's service plan, dated February 14, 2022, indicated R1 had diagnoses including dementia and dysphagia, and received services including assistance with activities of daily living (ADLs), meals, medication management, compression stockings, toileting, housekeeping, and laundry. R2 was admitted November 2, 2020, and began receiving assisted living services on August 1, 2021. R2's service plan, dated November 15, 2021, indicated R2 had diagnoses including type 2 diabetes mellitus, prostate cancer, and major depression, and received services including assistance with medication management, blood glucose (BG) monitoring, catheter care, housekeeping, and laundry. R3 was admitted December 29, 2022, and had diagnoses including dementia. R3's service plan, dated April 3, 2023, indicated R3 received services including assistance with ADLs, meals, medication management, housekeeping, and laundry. R1, R2, and R3's resident agreements, signed, August 22, 2018, October 1, 2020, and December 6, 2022, respectively, each included a Special Care for Alzheimer's Disease and Related Dementias disclosure statement. The disclosure	02110		

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02110	Continued From page 42 lacked descriptions of the following: -evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; -limiting the use of public address and intercom systems for emergencies and evacuation drills only; -transportation coordination and assistance to and from outside medical appointments; and -safekeeping of residents' possessions. On June 1, 2023, at 12:04 p.m., licensed assisted living director (LALD)-A stated they have no updated policies, and corporate did not provide policies. LALD-A further stated she was buying updated policies. LALD-A further stated they did not have specific dementia care policies, but provided information in the contract, and might have some additional information in the welcome packet. -at 4:45 p.m., LALD-A stated she did not have additional dementia care policies beyond the 2 provided, which were related to Dementia Disclosure Requirements and Staff Training Requirements (the policies provided were not updated to reflect current statutory requirements). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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02310	Continued From page 43	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of two residents (R3) who utilized grab bars (consumer bed rail). This resulted in an immediate correction order issued on May 31, 2023, at 6:10 p.m. In addition, the licensee failed to ensure proper safe storage of oxygen (O2) tanks for one of one resident (R1). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: BED RAIL R3's record lacked documented evidence the use of grab bars (consumer bed rails) was identified and assessed for risk of entrapment and falls, including but not limited to, proper installation	02310		

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02310	Continued From page 44 according to manufacturer guidelines, check for recall and education on the risk and benefits of using the bed rail device. R3 was admitted December 29, 2022, and had diagnoses including dementia, urinary tract infection, and osteoporosis. Their service plan dated April 3, 2023, indicated R3 received services including assistance with medication management, bathing, activities of daily living (ADLs), meals, housekeeping, and laundry. R3's individual abuse prevention plan (IAPP) and comprehensive assessment, both dated April 27, 2023, indicated R3 did not "have side rails/bed positioning devices" or bed mobility devices. On May 31, 2023, at 8:33 a.m., during an observation of cares, R3's bed was observed to have a consumer-style bed rail on both sides near the head of the bed. The left side rail was a white U-shaped bar, approximately 16 inches wide with a horizontal cross-bar, positioned between the mattress and bed frame, and secured to the frame with a safety retention strap. The right side rail was a gray U-shaped bar with a black foam grip at the top, approximately 16 inches wide with 2 horizontal cross-bars, positioned between the mattress and bed frame, and not secured with a safety retention strap. On May 31, 2023, at 8:50 a.m., unlicensed personnel (ULP)-G stated R3 just moved in a few months ago, and has had the grab bars on the bed since she moved in. ULP-G stated staff were taught to be sure a bed rail was in the "up" position while a resident was in bed, but did not recall any training regarding "grab bars" (consumer bed rails).	02310		

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02310	Continued From page 45 On May 31, 2023, at 2:23 p.m., R3 stated she did not remember talking to anyone in the facility about the risks of using grab bars. R3 stated they had not mentioned anything about them before today. R3 further stated they were a great help to her to sit up and move around in bed. On May 31, 2023, at 2:40 p.m., registered nurse (RN)-C stated they had not provided any education regarding risks associated with the consumer bed rails for R3 or their family, and had not checked the bed rails for recalls. RN-C stated they audited the facility for bed rails and grab bars, but that was done before R3 moved in (December 2022), and they were not aware the bed rails were present on R3's bed. On May 31, 2023, at 4:05 p.m., R3's family (F)-H stated R3's bed rails were added to her bed at the time she moved into the facility in December 2022. F-H further stated they might have had discussions regarding the risks of the bed rails at that time, but could not say for sure. F-H stated she was not sure of the manufacturer of the two bed rails, but would look for that information. The Food and Drug Administration's (FDA) A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients [residents] who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the	02310		

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02310	Continued From page 46 patient safe." The licensee's Side Rail Safety Assessment policy dated August 28, 2020, indicated, "Staff will alert the RN or licensed professional if a client [resident] has any type of side rail or similar equipment and the RN or licensed professional will then evaluate whether the side rail appears to be safe for the client. The RN or licensed professional will educate the client, the client's representative and/or family members about the risks related to side rails, and if the client's side rail does not appear to meet FDA standards, the RN or licensed professional will recommend to the client, the client's representative, the client's involved family members that the side rail be removed and will recommend alternative options to reduce the risk of a fall out of bed. The RN or licensed professional will document these conversations and recommendations." Minnesota Department of Health Assisted Living Resources and Frequently-asked Questions (FAQ) regarding consumer bed rails, updated April 25, 2023, indicated, "The licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls" or if a restraint; identified licensee must ensure consumer bed rails were securely attached and "should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information." The FAQ indicated, "The licensee must ensure the resident and/or resident's responsible party has been educated on the risk	02310		

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02310	Continued From page 47 for injury up to and including death due to entrapment." Additionally, "Licensees should have a process in place for monitoring and unlicensed personnel reporting new bed rails for nurse assessment." including if installed by the family. The FAQ further identified, "If a licensee is unable to locate manufacturer's guidelines, they are unable to assess and determine if the portable bed rail is being used appropriately and installed properly. This results in an imminent safety risk for the resident." The FAQ noted the information identified above must be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate An immediate correction order was issued on May 31, 2023, at 6:10 p.m. On June 1, 2023, at 7:00 p.m., the immediacy of the order was lifted. The scope and level remained at a 3/G. OXYGEN STORAGE R1 was admitted September 10, 2018, and began receiving assisted living services on August 1, 2021. R1's service plan, dated February 14, 2022, indicated R1 received services including assistance with activities of daily living (ADLs), meals, medication management, compression stockings, toileting, housekeeping, and laundry. R1's change of condition assessment, dated April 21, 2023, by RN-C, indicated R1 used O2 as needed (PRN) via an O2 concentrator (a tankless machine that produces O2). The assessment further indicated R1 had portable O2 tanks for backup use, and needed assistance with refilling portable O2 tanks.	02310		

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02310	Continued From page 48 On May 31, 2023, at 9:22 a.m., R1's room was observed to have 3 O2 tanks sitting on the floor near a window, and not secured to prevent tipping. A portable O2 tank filling device was observed sitting atop an O2 concentrator. The equipment was plugged in, but not turned on, had no tubing attached, and appeared unused. On May 31, 2023, at 10:08 a.m., ULP-I stated R1 had portable O2 tanks delivered to the facility after she was hospitalized in April 2023. ULP-I stated staff were trained on filling O2 tanks, and trained to be sure the correct tank and flow rate were used for a resident using O2. ULP-I was not aware of any storage requirements for O2 tanks. On May 31, 2023, at 10:38 a.m., RN-C stated R1 had PRN O2 ordered after returning from the hospital, but had not needed to use it. RN-C further stated she was not aware there were portable O2 tanks stored in R1's room. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements (based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code), dated April 16, 2020, indicated the types of hazards associated with oxygen as: 1) General fires and explosions enhanced by oxygen-rich atmospheres 2) Mechanical problems such as physical damage to compressed gas cylinders. The guidance further indicated, "when storing up to 300 cubic feet (ft^3) of oxygen, cylinders must be secured (chains or racks) to prevent them from falling over". Corner Home Medical's "Customer Info Booklet" dated 2023, indicated, "Small [oxygen] cylinders	02310		

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02310	Continued From page 49 should be stored standing up if possible, but should be in a rack or box to prevent falling. If necessary, they can be stored in a lying down position but placed so that they do not roll or cause a tripping hazard." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility, including statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of	03090		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03090	Continued From page 50 the residents). The findings include: On May 30, 2023, at 11:45 a.m., during a tour of the facility with registered nurse (RN)-C, the entrance to the facility lacked the required, verbatim notice to visitors regarding electronic monitoring. RN-C stated she was aware of the required posting, but they had not posted the notice yet. The licensee's Electronic Monitoring policy, dated August 24, 2020, indicated the licensee, "shall post a sign at each facility entrance accessible to visitors that states, 'Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities'." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Location:
Iris Park Commons
1850 University Avenue West
St Paul, MN55104
Ramsey County, 62

Establishment Info:
ID #: 0038957
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

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

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
	1	2	1

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.

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: MICHAEL J. PATTERSON

Certification Number: FM114297 Expires: 09/21/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

ROBERT JONES
DIRECTOR OF DINING OPERATIONS

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us