Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 22, 2022

Licensee
Sandstone Golden Horizons
1109 Lundorff Drive
Sandstone, MN 55072

RE: Project Number(s) SL33254015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on November 30, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

LICENSING ORDERS
The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The Department of Health imposes 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 Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should be addressed 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 Department of Health within 15 business days of the correction order receipt date. 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Case DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33254	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED 11/30/2022

NAME OF PROVIDER OR SUPPLIER: **SANDSTONE GOLDEN HORIZONS**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1109 LUNDORFF DRIVE, SANDSTONE, MN 55072**

(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 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: SL33254015-0 On November 28, 2022, through November 30, 2022, 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 29 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing 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	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 29 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 November 30, 2022, for the specific	0 480		

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0 480	Continued From page 2 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 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 infection control program that complied with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, 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 all staff, residents and visitors.)	0 510		

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0 510	Continued From page 3	0 510		

Findings include:

Unlicensed personnel (ULP)-E
ULP-E was hired on August 4, 2020, to provide assisted living services for licensee's dementia care residents.

On November 29, 2022, at 7:53 a.m., the surveyor observed ULP-E provide medication administration, which included oral medication, insulin injection, ointment application, eye drop medication, and glucose (sugar) check, without performing hand hygiene between providing medication and treatment services to R2 when donning (putting on) and doffing (taking off) gloves.

ULP-D
ULP-D was hired on November 15, 2017, under the comprehensive license and continued to provide assisted living services for licensee's dementia care residents under the assisted living with dementia care license.

On November 29, 2022, at 8:25 a.m., the surveyor observed ULP-D provide medication administration, which included oral medications, insulin injection, glucose check and application of compression stockings (TEDs), without performing hand hygiene between providing medication and treatment services to R5 when donning and doffing gloves.

ULP-D and ULP-E donned the gloves without application of any hand sanitizer or hand washing prior to changing tasks. Once all tasks were completed, ULP-D and ULP-E doffed their gloves and returned to the medication carts to document in the electronic medication record (EMR) without

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0 510	Continued From page 4 completing any hand hygiene. On November 29, 2022, at 3:45 p.m., clinical nurse supervisor (CNS)-B stated the registered nurse trained, "every time they change gloves, they should wash their hands with hand sanitizer or soap and water." The licensee's Infection Control Hand Washing policy dated March 18, 2020, indicated hand hygiene would be completed between resident tasks and before donning and after doffing gloves. No further information 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 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 tenant residents. (b) The facility must provide emergency and	0 680		

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0 680	Continued From page 5	0 680		

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 prominently post an emergency disaster plan.

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 is 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:

During a tour of the facility on November 28, 2022, at approximately 11:30 a.m., the surveyor observed no signage or information posted regarding the licensee's emergency plan at the facility entrance, hallways, hallway exit doors, or in the main living areas.

On November 28, 2022, at approximately 12:50 p.m., licensed assisted living director interim (LALDI)-A stated licensee "has it somewhere". LALDI-A stated it was her first day in the building as the interim LALD.

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0 680	Continued From page 6	0 680		

On November 29, 2022, at approximately 12:35 p.m., LALDI-A provided a black binder to the surveyor labeled emergency plan. LALDI-A confirmed the black emergency binder was found on LALDI-A's desk within a stack of papers and was incomplete. Licensee lacked the following item as part of licensee's customized emergency preparedness plan:
- post an emergency disaster plan prominently.

The licensee's Emergency Preparedness policy dated March 18, 2020, did not address emergency plan posting requirements.

No further information was provided.

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

0 780 SS=F — 144G.45 Subd. 2 (a) (1) Fire protection and physical environment — 0 780

(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

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0 780	Continued From page 7 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 29, 2022, between 10:50 a.m. and 11:55 a.m., survey staff toured the facility with the clinical nurse supervisor (CNS)-B. During the facility tour, survey staff observed that the smoke alarm bracket was empty in resident sleeping room 208. This room was vacant at time of survey. CNS-B confirmed during the tour interview that this smoke alarm was missing. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 8 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan reflected the current services provided and included all required content for two of three residents (R1, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01650		

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01650	Continued From page 9	01650		

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 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
R1 was admitted for services on December 11, 2021.

R1's diagnoses included chronic obstructive pulmonary disease (COPD) (progressive lung disease), mild cognitive impairment, and chronic pain.

R1's Service Plan dated December 14, 2021, indicated R1 required assistance with bathing, medication administration, behavior management, and safety checks.

R1's physician orders, dated June 16, 2022, indicated R1 required assistance with TED (compression) stockings twice daily.

On November 28, 2022, at 1:35 p.m., the surveyor observed R1 lying on his bed. There was a nebulizer machine on R1's kitchen table. The surveyor observed unlicensed personnel (ULP)-D administer R1's afternoon medication. The surveyor asked ULP-D if staff assist R1 with the nebulizer, ULP-D stated, "once in a while."

R1's Service Plan dated December 14, 2021, lacked evidence of inclusion or revisions to include TEDs, assistance with nebulizer

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equipment, and laundry services.

R5
R5 was admitted for services on May 18, 2022.

R5's diagnoses included COPD and diabetes mellitus II and hypertension (elevated blood pressure).

R5's Service Plan dated May 18, 2022, indicated R5 required assistance with bathing, medication administration, glucose (sugar) checks, diabetic nail care, housekeeping, and laundry.

On November 29, 2022, at 8:25 a.m., the surveyor observed R5 sitting in a chair in her room. The surveyor observed ULP-D administer R5's morning medications, check R5's glucose (sugar) levels, and apply TEDs. Upon completion of the tasks, ULP-D assisted R5 with ambulation to the dining room.

R5's service plan lacked evidence of inclusion or revisions to include TEDs application and removal, and ambulation assistance.

Additionally, R1 and R5's service plans lacked the following required content:
- a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; and
- the identification of staff or categories of staff who will provide the services.

On November 29, 2022, at approximately 3:45 p.m., clinical nurse supervisor (CNS)-B confirmed the service plans did not include the tasks being performed for managing and monitoring R1 and R5's individual needs and lacked the above noted

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requirements. Additionally, CNS-B stated, "We redo service plans yearly, I think. After the first of the year after their 90 day."

The licensee's Service Plan policy dated July 20, 2021, indicated the service plan would include a description of all services to be provided, a fee for the service and the frequency, identification of staff or categories of staff who would provide the services.

No further information was provided.

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

01760 SS=F | 144G.71 Subd. 8 Documentation of administration of medication | 01760

Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process were

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followed for two of two employees, (unlicensed personnel (ULP)-E, ULP-D) observed during medication administration.

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:

ULP-E
On November 29, 2022, at 8:15 a.m., the surveyor observed ULP-E administer R4's morning medications in the memory care unit. ULP-E set up R4's morning medications from bubble packs (foil backed medication organizer) located in a locked medication cart to a medication cup. The surveyor observed ULP-E verify the medications and exit the medication room. ULP-E entered the dining room and approached the dining table R4 was sitting eating breakfast with five other residents present. ULP-E placed the medication cup on the table in front of R4 and exited the dining room.

Directly following the above observation ULP-E stated, "she doesn't like us watching her [R4] take them. We hand them to her; she has been in here about a month."

ULP-D
On November 29, 2022, at 8:38 a.m., the surveyor observed ULP-D administer R5's morning medications. ULP-D removed R5's morning medications from a locked medication

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cart and popped each medication from a bubble pack into a medication cup. ULP-D entered R5's room and administered the medications. The surveyor observed ULP-D did not verify the medications prior to administration.

Directly following the above observation ULP-D stated the medications were unable to be electronically verified in the electronic medication administration record (EMAR) prior to administration as the system required a glucose (sugar) check result be entered prior to opening the option for verification of medications. ULP-D stated R5's preference was to have all morning tasks to include medication administration completed at the same time, "then I go in and verify and mark administered on all her meds."

On November 29, 2022, at 3:45 p.m., clinical nurse supervisor (CNS)-B stated ULP's should remain with residents during medication administration, "they need to watch them take them" and "we agree it's not the correct process for medication administration."

The licensee's Medication Management Services policy dated March 18, 2020, indicated medications always need to be administered according to the "6 Rights", right person, right medication, right time, right route, right dose, right chart/record. Before ULP's perform the procedure of medication administration, the RN has instructed the ULP in the proper methods to administer medications.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7)

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01810	Continued From page 14	01810		
01810 SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure over the counter (OTC) drugs were stored as appropriate for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted for services on December 11, 2021. R1's diagnoses included chronic obstructive pulmonary disease (COPD) (progressive lung disease), mild cognitive impairment, and chronic pain. R1's Service Plan dated December 14, 2021,	01810		

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indicated R1 required assistance with medication administration.

On November 28, 2022, at 1:35 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R1's afternoon medications from a locked medication cart. Upon entering R1's room, the surveyor observed three bottles of Advil PM 200 milligrams (mg) 30 capsules each bottle, a bottle of melatonin 12 mg/ 40 count and a bottle of 81 mg aspirin sitting on R1's kitchen table. ULP-D stated, "he takes them himself."

R1's Assessment dated September 2, 2022, indicated R1 required assistance with medication administration due to R1's inability to comprehend and remember medication regimen and staff were to administer all medications. Additionally, R1's Assessment indicated a face-to-face medication assessment had been completed with the registered nurse (RN) to include all medications the resident was known to be taking.

R1's physician orders dated June 16, 2022, included one antianxiety/antidepressant, one cholesterol reducer, two antihypertensive, one heart rate stabilizer, two pain medications, one iron supplement, one inhaler, one eyedrop, one topical and one stomach acid reducer. R1's physician orders did not include Advil PM, melatonin, or aspirin.

On November 28, 2022, at 3:18 p.m., clinical nurse supervisor (CNS)-B verified OTC medications are to be stored in the locked medication cart and verified R1 keeps OTC medications in his room. Additionally, CNS-B stated, "he goes and buys stuff he thinks he needs; he doesn't think we need to know about. His MD [medical doctor] knows about it". CNS-B

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added, "he [R1] is on a narcotic contract program with his MD, he sees him every month, he doesn't have control of his meds". On November 28, 2022, at approximately 3:30 p.m., the surveyor requested to review nursing or physician notes from R1's monthly physician appointments. CNS-B was unable to provide requested documentation.

On November 29, 2022, at approximately 1:00 p.m., the surveyor was provided a copy of a physician update CNS-B sent to R1's physician the morning of November 29, 2022. The update consisted of a list of the medications the surveyor had observed in R1's room and a request to the physician for R1 to self-administer.

The licensee's Storage of Medication policy dated March 18, 2020, indicated licensee stores medication in a safe and secure manner that prevents diversion and is only accessible to designated staff of licensee.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01870 SS=D | 144G.71 Subd. 18 Medications provided by resident or family me | 01870

When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record.

This MN Requirement is not met as evidenced

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01870	Continued From page 17	01870		

by:
Based on observation, interview, and record review, the licensee failed to ensure residents were assessed for self-administration of medications for one of one resident (R1) who self-administered medications.

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

The findings include:

R1's diagnoses included chronic obstructive pulmonary disease (COPD) (progressive lung disease), mild cognitive impairment, and chronic pain.

R1's Service Plan dated December 14, 2021, indicated R1 required assistance with bathing, medication administration, behavior management, and safety checks.

On November 28, 2022, at 1:35 p.m., the surveyor observed following medications in R1's room:
- Advil PM 200 milligram (mg) (sleep aid);
- melatonin 12 mg (sleep aid); and
- aspirin 81 mg.

The above medications were not included in R1's prescriber orders, dated June 16, 2022.

R1's medication assessment, dated September

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2, 2022, indicated R1 was not able to safely self-administer his own medications. Additionally, the assessment indicated R1 was unable to comprehend or remember his medication regimen and staff are to administer all medications.

On November 28, 2022, at approximately 1:40 p.m., unlicensed personnel (ULP)-B verified the above medications were stored in the resident's room and stated R1 takes the medications on his own.

On November 28, 2022, at 3:18 p.m., clinical nurse supervisor (CNS)-B confirmed R1 stored medications in his room and stated, "he goes and buys stuff he thinks he needs; he doesn't think we need to know about. He has a face to face with his physician every month for a pain medication contract." The surveyor requested documentation of the face-to-face visits, CNS-B was unable to provide the requested documentation.

The licensee's Assessment policy, dated March 1, 2021, indicated the registered nurse (RN) would complete a medication assessment to review prescriptions, over the counter medications and determine if the resident is able to administer medications safely or if the resident will need medication assistance.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01880 SS=F	144G.71 Subd. 19 Storage of medications	01880		

An assisted living facility must store all

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01880	Continued From page 19	01880		

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:
Based on observation and interview, the licensee failed to ensure prescription medications were stored in a secured manner allowing only authorized personnel access.

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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On November 28, 2022, at 12:05 p.m., in the presence of clinical nurse supervisor (CNS)-B, the surveyor observed an open door to the nursing office, located next to the main entrance doors of the facility. The surveyor observed a medication refrigerator located in plain view under the cupboard which lacked a lock to secure medications.

On November 28, 2022, at approximately 12:20 p.m., in the presence of CNS-B, the surveyor observed an open door to a nursing office located in the memory care unit. The surveyor observed a medication refrigerator located in plain view under the cupboard and lacked a lock to secure the medications within.

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01880		01880		

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On November 28, 2022, at 1:15 p.m., registered nurse (RN)-C provided the surveyor an inventory list for both unsecured medication refrigerators. The medication refrigerators contained insulin, antibiotic, and fever/pain reducing medications for 14 of the 29 residents.

The inventory list contained the following medications:
- Lantus insulin
- Bydureon insulin
- Ozempic insulin
- Tresiba insulin
- Cefalexin antibiotic
- Mounjaro insulin
- Basaglar insulin
- Novolog insulin
- Levemir insulin
- liquid acetaminophen

On November 28, 2022, at approximately 1:15 p.m., RN-C confirmed the medication refrigerators contained unsecured medication and were kept in a common area accessible to all staff. RN-C stated, "we usually have the doors closed."

The licensee's policy Storage of Medications dated March 18, 2020, indicated medications stored outside of the locked medication carts are locked in the medication storage cabinet or refrigerator in the locked nurse's office.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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01890	Continued From page 21	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, licensee failed to date time-sensitive medications with an opened-on date for three of three residents (R2, R5, R8) and failed to ensure medications were labeled for one of three residents (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 28, 2022, at approximately 11:20 a.m., clinical nurse supervisor (CNS)-B stated licensee provided medication management services for residents who received services. On November 28, 2022, at approximately 12:15 p.m., the surveyor reviewed medications in the locked medication carts with CNS-B. R2	01890		

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R2's Prednisolone acetate 1% 5 milliliters (ml) lacked a label to indicate the date the eye drops were opened and when the eye drops would expire.

The manufacturer's instructions for the use of Prednisolone acetate eye drops dated May 2022 indicated use of eye drops should end with the expiration date on the bottle.

R2's Humalog Kwikpen 100 units (u)/ml lacked a label to indicate the date the insulin pen was opened and when the insulin pen would expire.

The manufacturer's instructions for the use of Humalog Kwikpen insulin dated 2019 indicated the insulin pen should be discarded 28 days from the open date.

R2's Toujeo Solostar 300 u/ml insulin pen lacked a label to indicate the date the insulin pen was opened and when the insulin pen would expire.

The manufacturer's instructions for the use of Toujeo Solostar insulin pen dated 2019 indicated the insulin pen should be discarded 42 days from the open date.

R5
R5's Lantus Solostar 100 u/ml lacked a label to indicate the date the insulin pen was opened and when the insulin pen would expire.

The manufacturer's instructions for the use of Lantus Solostar insulin pen dated 2019 indicated the insulin pen should be discarded 28 days from the open date.

PRESCRIPTION LABEL

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01890	Continued From page 23 R8 was admitted for services on October 31, 2020, and was discharged on October 5, 2022. On November 28, 2022, at approximately 12:15 p.m., the surveyor reviewed medications in the locked medication cart, located in the memory care unit with CNS-B. The surveyor observed one opened vial of Lidocaine 1% 100 milligram (mg) /1 milliliter (ml) inside the top drawer of the medication cart. The vial of Lidocaine lacked a prescription label, an open date, and an expiration date. CNS-B stated the Lidocaine belonged to R8 and confirmed R8 had passed away August 3, 2022. On November 28, 2022, at approximately 12:45 p.m., CNS-B confirmed all time sensitive medications including the above noted time sensitive medications should be dated after opening with an open date and expiration date. CNS-B stated, "that's our bad." The licensee's Storage of Medications policy dated March 18, 2020, indicated all medications are stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	01910		

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part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.
(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.
(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R8) upon discharge.

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:

R8 was admitted for services on October 31, 2020, and was discharged on October 5, 2022.

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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
01910	Continued From page 25 R8's Discharge Summary dated October 5, 2022, indicated R8 received medication management services which included medication administration. R8's medical record lacked inclusion of a medication disposition. R8's Discharge Summary dated October 5, 2022, indicated medications were destroyed via RX Destroyer on August 3, 2022. On November 29, 2022, at 3:20 p.m., clinical nurse supervisor (CNS)-B stated he was continuing to look for the medication disposition, but was unable to locate it. The licensee's Medication Destruction policy dated March 18, 2020, indicated upon disposition of medications, licensee would document the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given or how it was disposed of, date of disposition, and names of staff and other individuals involved in the disposition. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33254	A. BUILDING: ______ B. WING ______	11/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDSTONE GOLDEN HORIZONS	**1109 LUNDORFF DRIVE SANDSTONE, MN 55072**

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01940	Continued From page 26 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan to include all required content for two of three residents (R1, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01940		

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01940	Continued From page 27	01940		

than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

During the entrance conference on November 28, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents.

R1
R1 was admitted for services on December 11, 2021.

R1's diagnoses included chronic obstructive pulmonary disease (COPD) (progressive lung disease), mild cognitive impairment, and chronic pain.

R1's Service Plan dated December 14, 2021, indicated R1 required assistance with bathing, medication administration, behavior management, and safety checks.

On November 28, 2022, at 1:35 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R1's afternoon medication. The surveyor asked ULP-D if R1 had his compression stockings (TEDs) applied during morning cares. ULP-D stated, "yes, he gets up and leaves very early. We have to assist him when he's ready or he leaves."

R1's physician orders, dated June 16, 2022, indicated R1 required assistance with TED stockings twice daily.

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01940	Continued From page 28	01940		

R1's 90-day reassessment dated September 2, 2022, indicated R1 required assistance with TED stockings application and removal daily.

R1's Service Plan dated December 14, 2021, lacked the inclusion of TEDs.

R5
R5's diagnoses included chronic obstructive pulmonary disease (COPD), diabetes mellitus II, and hypertension (elevated blood pressure).

R5's Service Plan dated May 18, 2022, indicated R5 required assistance with bathing, medication administration, glucose (sugar) checks, diabetic nail care, housekeeping, and laundry. R5's service plan lacked inclusion of TEDs.

On November 29, 2022, at 8:25 a.m., the surveyor observed R5 sitting in a chair in her room. The surveyor observed ULP-D check R5's glucose (sugar) levels and apply TEDs. ULP-D stated staff always assist R5 with the application and removal of TEDs.

R5's physician orders dated June 16, 2022, lacked provider's orders for TEDs.

R5's Individualized Treatment and Therapy Plan for November 2022 did not include TEDs treatments.

R5's Service Recap Summary dated November 2022 lacked inclusion of TEDs treatments and all required documentation.

R1 and R5's record lacked an Individualized Treatment and Therapy plan to include the following:
- a statement of the type of services that will be

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01940	Continued From page 29 provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On November 29, 2022, at approximately 3:45 p.m., CNS-B confirmed R1 and R5's Individualized Treatment and Therapy Plans lacked the above noted requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health	01950		

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professional has:
(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;
(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and
(3) communicated with the unlicensed personnel about the individual needs of the resident.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) instructed the unlicensed personnel (ULP) on proper treatment procedures, specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record for one of three residents (R5).

This practice resulted in a level two violation (a violation that did not harm a client'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:

R5 was admitted May 18, 2022.

R5's physician orders dated June 16, 2022, included furosemide 20 milligrams (mg) tab one time daily for congestive heart failure (CHF) (chronic progressive condition that affects the

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pumping power of your heart muscle) and can lead to edema (fluid buildup causing swelling). R5's physician orders lacked provider's orders for TEDs.

On November 29, 2022, at 8:25 a.m., the surveyor observed R5 sitting in a chair in her room. The surveyor observed ULP-D check R5's glucose (sugar) levels and apply compression stockings (TEDs).

R5's treatment record lacked inclusion of the application or removal of TEDs.

R5's service plan, dated May 18, 2022, lacked inclusion of the application or removal of TEDs.

R5's record lacked a treatment and therapy management plan with instructions regarding application or removal of TEDs and any specific instructions for ULPs.

On November 29, 2022, at approximately 8:30 a.m., ULP-D stated she received training from the RN on applying and removing TEDs and staff applied and removed R5's TEDs everyday.

On November 29, 2022, at 1:42 p.m., RN-C stated, "I'm not sure why we are putting on TEDs, that's not on anything anywhere."

On November 29, 2022, at 3:45 p.m., clinical nurse supervisor (CNS)-B confirmed there was no treatment management plan developed for R5's TEDs and stated, "she's been wearing them for many years. I will get an order for that, honestly I didn't know she had TED socks."

The licensee's Medication, Treatment and Therapy Administration by Unlicensed Personnel

Minnesota Department of Health

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01950	Continued From page 32 policy dated March 16, 2020, indicated ULPs that provide assistance with treatment and therapy administration would be trained and competency tested by the RN on the following: - the complete procedure for checking the residents treatment and therapy profile and any additional information; - administration of the treatment and therapy to the resident; - documentation, after assistance with treatment and therapy administration consistent with licensee's procedures for documenting in the medical administration record (MAR); and - before performing the procedures, the RN has developed written, specific instructions for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	01960		

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01960	Continued From page 33 Based on observation, interview, and record review, the licensee failed to ensure treatments or therapies were administered as prescribed, or to document the reason they were not provided to meet the resident's needs for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R5's diagnoses included chronic obstructive pulmonary disease (COPD), diabetes mellitus II, and hypertension (elevated blood pressure). R5's Service Plan dated May 18, 2022, indicated R5 required assistance with bathing, medication administration, glucose (sugar) checks, diabetic nail care, housekeeping and laundry. R5's service plan lacked inclusion of compression stockings (TEDs). On November 29, 2022, at 8:25 a.m., the surveyor observed R5 sitting in a chair in her room. The surveyor observed unlicensed personnel (ULP)-D check R5's glucose (sugar) levels and apply TEDs. ULP-D stated staff assisted R5 daily with the application and removal of compression stockings (TEDs). R5's physician orders dated June 16, 2022 lacked provider's orders for TEDs.	01960		

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01960	Continued From page 34	01960		

R5's Individualized Treatment and Therapy Plan for November 2022 did not include TEDs treatments.

R5's Service Recap Summary dated November 2022 lacked inclusion of TEDs treatments and all required documentation.

On November 29, 2022, at approximately 3:50 p.m., clinical nurse supervisor (CNS)-B confirmed R5's record lacked the required documentation and stated, "she's been wearing them for years. I'm in the process of talking with her nurse practitioner (NP). I will get an order for that. Honestly, I didn't know she had TED socks."

The licensee's Treatment and Therapy Management policy, undated, indicated documentation of treatments and therapies would be completed in the resident's treatment record and when treatments or therapies were not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders	01970		

There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be

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01970	Continued From page 35	01970		

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.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or an electronically recorded order was maintained for one of three residents (R5) who received a treatment managed by the provider.

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:

During the entrance conference on November 28, 2022, at approximately 11:15 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to residents in the facility.

R5's diagnoses included COPD and diabetes mellitus II, and hypertension (elevated blood pressure).

R5's Service Plan dated May 18, 2022, indicated R5 required assistance with bathing, medication administration, glucose (sugar) checks, diabetic nail care, housekeeping, and laundry.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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On November 29, 2022, at 8:25 a.m., the surveyor observed R5 sitting in a chair in her room. The surveyor observed ULP-D administer R5's morning medications, check R5's glucose (sugar) levels and apply compression stockings (TEDs).

R5's physician orders dated June 16, 2022 lacked provider orders for the TEDs.

On November 29, 2022, at approximately 3:50 p.m., clinical nurse supervisor (CNS)-B confirmed R5's record lacked the required treatment orders and stated, "she's been wearing them for years. I'm in the process of talking with her NP [nurse practitioner]. I will get an order for that. Honestly, I didn't know she had TED socks."

The licensee's Medication Treatment Orders policy dated March 16, 2020, indicated written orders must be obtained for any treatment therapy or medication administered by [facility name] to a resident. The registered nurse (RN) is responsible for assuring that current, authorized prescriber orders for medications, treatments or therapy services administered by the staff are kept on file in the residents record.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

Minnesota Department of Health

11 East Superior St.
Duluth

Type: Full
Date: *11/30/22*
Time: 11:00:00
Report: 1016221199

Food and Beverage Establishment Inspection Report

Location:
Sandstone Golden Horizons - MAIN KITCHEN
1109 Lundorff Drive
Sandstone, MN55072
Pine County, 58

Establishment Info:
ID #: 0038956
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 3202167300
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.

3-300B Protection from Contamination: cross-contamination, eggs
3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

SEVERAL ITEMS INCLUDING OATMEAL, FLOUR AND SUGAR DID NOT HAVE LABELS ON THEIR CONTAINERS. LABEL THESE CONTAINERS WITH NAME OF INGREDIENT.

Comply By: 11/30/22

Surface and Equipment Sanitizers

Hot Water: = at 167 Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Quaternary Ammonia: > 200 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 190 Degrees Fahrenheit - Location: CHILI
Violation Issued: No

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

Type: Full
Date: *11/30/22*
Time: 11:00:00
Report: 1016221199

Food and Beverage Establishment Inspection Report

Sandstone Golden Horizons - MAIN KITCHEN

Process/Item: Walk-In Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOOD FROZEN
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 36 Degrees Fahrenheit - Location: STRAWBERRIES
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: TURKEY
Violation Issued: No

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

COMMENTS:

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

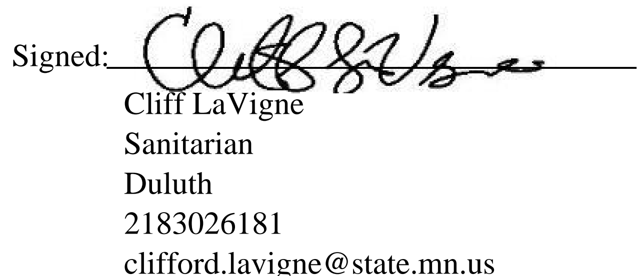
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1016221199 of 11/30/22.

Certified Food Protection Manager: JENNIFER ANN FISHER

Certification Number: FM30496 Expires: 08/02/23

Signed: ____________________
JENNIFER FISHER

Signed: 
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