Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

August 9, 2024

Licensee
Lakeland Health Services LLC
11840 Foley Boulevard Northwest
Coon Rapids, MN 55448

RE: Initial License Number 411097
Health Facility Identification Number (HFID) 39587
Project Number(s) SL39587015

Dear Licensee:

On August 6, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed March 6, 2024. The follow-up survey found the facility to be in compliance. Based on these findings, the condition(s) on the license were removed effective August 9, 2024.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division
HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

July 3, 2024

Licensee
Lakeland Health Services LLC
11840 Foley Boulevard Northwest
Coon Rapids, MN 55448

RE: Provisional Conditional License Number 411097
Health Facility Identification Number (HFID) 39587
Project Number(s) SL39587015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on June 4, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 60-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **September 1, 2024**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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), state correction orders issued pursuant to the last survey, completed on March 6, 2024, found not corrected at the time of the June 4, 2024, follow-up survey and subject to penalty assessment is as follows:

1730 - Individualized Medication Management Plan - 144g.71 Subd. 5 - $500.00

The details of the violations noted at the time of this follow-up survey completed on June 4, 2024 (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.

Also, at the time of this follow-up survey completed on June 4, 2024, we identified the following violation(s):

0340 - Correction Orders-144g.30 Subd. 5 - $500.00
2310 - Appropriate Care And Services - 144g.91 Subd. 4 (a) - $3,000.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. 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 provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders 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 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.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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 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. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRDAppealsForm**.

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

CONDITIONAL LICENSE ISSUED:
MDH will issue Lakeland Health Services LLC a 60-day extension of the conditional provisional assisted living facility license from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Lakeland Health Services LLC is in substantial compliance.

The following conditions have been rescinded:

- Consultant
- Reports

In addition, the following conditions will continue to be in effect on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate

temporary suspension and revocation of the provisional license.

b. **No new admissions:** Lakeland Health Services LLC will continue to not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Lakeland Health Services LLC.

a. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Lakeland Health Services LLC to correct the violations cited during the follow-up survey as well as to determine the overall practice of Lakeland Health Services LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

b. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

c. **Corrective Action Plan:** Lakeland Health Services LLC will continue to develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
   i. A statement of the concern
   ii. A description of what will happen to correct the concern
   iii. A target date for when each correction will be complete
   iv. Who is responsible to make sure it happens
   v. Current status of correction work
   vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Lakeland Health Services LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional provisional license period. If MDH determines Lakeland Health Services LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Lakeland Health Services LLC. If MDH determines Lakeland Health Services LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability**

to request a reconsideration under this enforcement action.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: ______ B. WING ______	R 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

(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: SL39587015-1 On June 3, 2024, through June 4, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on March 6, 2024. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued. An immediate correction order was identified on June 3, 2024, issued for SL39587015-1, tag identification 2310. On June 4, 2024, at 9:14 a.m., the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of I.	{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 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the	0 340		

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0 340	Continued From page 1 commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on March 6, 2024. 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	0 340		

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0 340	Continued From page 2 has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 3, 2024, at 10:20 a.m., unlicensed personnel/manager (ULP/M)-C stated she felt all corrections had been made. During the revisit survey on June 3, 2024, through June 4, 2024, the surveyor reviewed the licensee's policies and procedures, resident records, employee records, and conducted interviews. The licensee lacked evidence to indicate the orders issues on March 6, 2024, were corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the 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: No further information required.	{0 480}		
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	{0 780}		

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{0 780}	Continued From page 3 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 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 information required.	{0 780}		
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	{0 790}		

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{0 790}	Continued From page 4 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further information required.	{0 790}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further information required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	{0 810}		

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{0 810}	Continued From page 5 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further information required.	{0 810}		
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for	{01730}		

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{01730}	Continued From page 6 each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a current individualized medication management plan for one of one resident (R3).	{01730}		

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{01730}	Continued From page 7	{01730}		

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:

On June 3, 2024, at 10:20 a.m., unlicensed personnel/manager (ULP/M)-C stated the licensee provided medication management services to residents at the facility.

R3 admitted to the facility on April 12, 2024, with diagnoses including other organic related intellectual disability, ankylosing spondylitis of multiple sites in the spine, incontinence, obstructive sleep apnea, asthma, chronic pain syndrome, and insomnia.

R3's Service Plan dated April 12, 2024, noted services including assistance with bathing, dressing, grooming, laundry, behavior management, medication administration, and safety checks daily.

R3's record contained a Medication List from Allina Health Forest Lake Clinic dated April 16, 2024. The list included:
- multivitamin/iron/folic acid (Certavite-Antioxidant) - 18-400 milligrams (mg)/microgram (mcg) 1 tablet daily;
- pregabalin (Lyrica) - 100 mg by mouth;
- ropinirole (Requip) - 0.25 mg three times daily; and

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LAKELAND HEALTH SERVICES LLC	**11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448**

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{01730}	Continued From page 8 - vitamin D3/vitamin K2 (MK4) - one tablet daily. R3's May 2024 Med [Medication] Admin [Administration] Summary listed medications as prescribed, times to administer, and staff initials to indicate the medications had been given. However, it lacked the above listed medications. R3's Individualized Medication Management Plan dated April 26, 2024, noted the facility managed R3's medications, and the registered nurse reviewed the prescription medications, over-the-counter medication, and supplements. It also noted "Current list of medications were reviewed with the resident: indications, dosage, how often they are taken, rout {sp} of administration were discussed and the resident verbalized understanding." On June 4, 2024, at 10:00 a.m., ULP/M-C stated the over-the-counter medications were not covered by insurance and R3 could not afford to purchase them herself. R3 has a medical appointment on June 7, 2024, and the prescriber is going to have lab levels drawn to see if the medications remain necessary. ULP/M-C stated R3 was in the middle of changing prescribers and they were working to get the medications in order. CNS-A stated they had contacted the prescriber's nurse who sent the electronic signed prescriptions available for the medications, but these did not include the prescription for the above listed medications. In addition, CNS-A stated he had not contacted the prescriber to verify if these medications should be continued or discontinued. The licensee's Assessment of Medications policy dated February 16, 2024, noted the registered nurse (RN) would perform an assessment to	{01730}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: ______ B. WING ______	R 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	**11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448**

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{01730}	Continued From page 9 include: - an identification of all medications, including over the counter medications; - a medication reconciliation to identify the most accurate list of medications the resident was taking including the name, dosage, frequency and route by comparing the resident record to an external list of medications obtained from the resident, hospital, prescriber or other provider; and - the effectiveness of the drug therapy. The licensee's Service Plan for Medication Management policy dated February 16, 2023, noted the medication management plan included any resident-specific requirements related to documentation of medication administration and verification that all medications were administered as prescribed. It also noted the RN was responsible for preparing and documenting the medication management plan and the plan would be kept current and updated with any changes. No further information was provided.	{01730}		
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 ensure the care and services were provided according to acceptable	02310		

02310 | 02310

Continued From page 10

health care and medical or nursing standards for one of one resident (R3) with a consumer bedrail.

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:

This practice resulted in an immediate order for correction on June 3, 2024.

On June 3, 2023, at 12:30 p.m., the surveyor observed R3's bed with unlicensed personnel/assisted living director in residency (ULP/ALDIR)-B. The bed was observed to be a twin sized mattress with an upside-down U-shaped device on the left side of the bed. The device was black metal and was placed between the mattress and box spring. The device had a camouflage-colored ratchet strap that went through the openings on the device and ran between the bed frame and mattress, and down around the bed frame. It was secure to the frame with the ratchet strap. Below the U-shaped top, a surge protector was attached to the horizontal bar that rested on top of the box spring with two zip ties and had two charging devices plugged into it. One cord was wrapped around the rail and the other was loosely wrapped through the rail. The mattress was approximately 3 inches from the side of the device. R3 was in her room at this time, and stated she utilized the rail to get in and out of bed, and to turn and reposition herself in

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02310	Continued From page 11	02310		

bed.

R3's diagnoses included other organic related intellectual disability, ankylosing spondylitis of multiple sites in the spine, incontinence, obstructive sleep apnea, asthma, chronic pain syndrome, and insomnia.

R3's Service Plan dated April 12, 2024, noted services including assistance with bathing, dressing, grooming, laundry, behavior management, medication administration, and safety checks daily.

R3's Admission Assessment dated April 13, 2024, indicated R3 was independent with bed mobility, noted R3 was forgetful, gait appeared unsteady, instructing staff to supervise or stand by assist when resident ambulates. It noted R3 was at risk for falls, has hypotension, has shoulder pain and headaches. Under bed safety, it noted a low bed with an orthopedic mattress. "Resident stated she purchased the bedrail that she placed on the left side of the bed. Resident stated she definitely needs that bedrail to get out of bed. Resident was educated about the risks and benefits of using unapproved bedrail. Bedrail was tightly connected to the bed." Under section titled bed rails area appropriate based upon assess need, noted "No. This is unapproved bedrail that the resident purchased on her own. The resident insisted that it is helping her to get out of bed. The resident stated understanding of the risks and benefits of using the bedrail on the left side of the bed." It noted "no" under if bed rails are in use, are there any alternatives that could be used in place of the bed rails.

An untitled and undated form signed by R3 noted discussion of the risks and benefits of the use of

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02310	Continued From page 12	02310		

the bedrails.

R3's record lacked an assessment of the device to include;
- condition and description (i.e., and area large enough for a resident to become entrapped) of the bed rail;
- installation and use according to manufacturer's guidelines;
- physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation;
-any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and
-evidence the device had not been recalled.

On June 3, 2024, at 12:40 p.m., clinical nurse supervisor (CNS)-A stated he assessed R3 with the use of the device and provided education on the risks versus benefits. CNS-A stated he had offered to change the bed to a medical bed, but R3 did not want to change it. He stated he was not able to find any documentation for the make or model of the device and had not checked for a recall.

On June 3, 2024, at 1:30 p.m., ULP/manager (ULP/M)-C stated she was the one that installed the device to the bed, and stated she looked up the bed rail make and model online and followed the directions to be sure it was secured correctly to the bed. ULP/M-C stated R3 had an order for a hospital bed at her previous facility, but they did not follow through, and currently she was working with the care coordinator and R3 is in the middle of changing providers. ULP/M-C stated R3 has a medical appointment on June 7, 2023, and she will get the order for the hospital bed at that time so it can be sent to the county to get ordered. In

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02310	Continued From page 13 addition, ULP/M-C stated she had checked the Consumer Product Safety Commission (CPSC) and the device had not been recalled. At 3:20 p.m., ULP/M-C stated she was aware the strap was not the same one pictured in the user guide and let CNS-A know about this. They spoke with R3, but she refused to get rid of this rail, which is why they are working on getting a hospital bed with bedrails. The Medline Bed Assist Bar User Guide dated revised December 15, 2009, noted the storage pocket should be attached to the outside of the assist bar. The guide noted to secure the strap around the bed frame on the opposite side of the bed and tighten. The picture on the directions is a black strap, not camouflage-colored, as was used on R3's bed. The licensee's Side Rail Use policy dated February 16, 2023, noted before implementing side rails for a resident, the RN would conduct an assessment including bed mobility, would consider the resident's request for the bedrails during the evaluation. It noted the RN was responsible to ensure the bedrails in use were safe and properly maintained. It noted portable rails would be used consistent with the manufacturer's recommendations. It noted the RN would assess the need for the rails at least every 90 days to include inspection of the rails for any functional problems or maintenance issues, verifying the mattress was the proper size and prevented entrapment between the mattress and rail, and gaps between the mattress and rails were reduced, and ensure that the rails were installed correctly and there were no areas for possibly entrapment or falls. It also noted documentation would include the measurements, installation, condition, results of the physical	02310		

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inspection of the rails and mattress for areas of entrapment and stability, and any other information to mitigate safety risks.

The Minnesota Department of Health (MDH) website updated April 3, 2024, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated documentation about a resident's bed rails includes, but is not limited to:
-purpose and intention of the bed rail;
-condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;
-the resident's bed rail use/need assessment;
-risk vs. benefits discussion (individualized to each resident's risks);
-the resident's preferences;
-installation and use according to manufacturer's guidelines; and
-physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation.
In addition, the FAQ indicated "licensees should refer to the Consumer Product Safety Commission (CPSC) for the most up-to-date information related to portable bed side rail recall information."

No further information was provided.

TIME PERIOD FOR CORRECTION: IMMEDIATE

Immediacy of this order was removed on June 4, 2024, as confirmed by supervisor review, however noncompliance remains at a scope and level of three, isolated (G).

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered
April 1, 2024

Licensee
Lakeland Health Services, LLC
11840 Foley Boulevard Northwest
Coon Rapids, MN 55448

RE: Provisional Conditional License Number 411097
Health Facility Identification Number (HFID) 39587
Project Number SL39587015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 6, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **June 30, 2024**.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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 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.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

CONDITIONAL LICENSE ISSUED:

MDH will issue Lakeland Health Services, LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Lakeland Health Services, LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Lakeland Health Services, LLC will not admit any new residents under its conditional assisted living facility license until MDH removes the "no new admissions" condition. Lakeland Health Services, LLC must provide the Department:

    i. A list of the names and birthdates of any individuals Lakeland Health Services, LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident.
        2. Physical location of each resident.
        3. Current payment source for services.

4. If Elderly Waiver, the name and contact information of the care coordinator/case manager.
5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative.

c. **Consultant:** Lakeland Health Services, LLC will contract with an RN to provide consultation concerning all resident(s) to whom Lakeland Health Services, LLC provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Lakeland Health Services, LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Lakeland Health Services, LLC and MDH must review the RN's credentials and approve the selection. Lakeland Health Services, LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Lakeland Health Services, LLC in an effort to help Lakeland Health Services, LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Lakeland Health Services, LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Lakeland Health Services, LLC and the RN consultant about a change. Each report will be electronically submitted to Jessie Chenze, Supervisor, State Evaluation Team, Health Regulation Division, at jessie.chenze@state.mn.us. Jessie Chenze can be reached at 218-332-5175 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by

the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Lakeland Health Services, LLC to correct the violations cited during the survey as well as to determine the overall practice of Lakeland Health Services, LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. **Corrective Action Plan:** Lakeland Health Services, LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
   i. A statement of the concern
   ii. A description of what will happen to correct the concern
   iii. A target date for when each correction will be complete
   iv. Who is responsible to make sure it happens
   v. Current status of correction work
   vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Lakeland Health Services, LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Lakeland Health Services, LLC is in substantial compliance on the follow up survey, MDH will remove the conditions from Lakeland Health Services, LLC's assisted living facility license, and Lakeland Health Services, LLC will correct any outstanding violations indentified during the survey. If Lakeland Health Services, LLC is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING RECONSIDERATION
Pursuant to Minn. Stat. § 144G.16, Subd. 4, a provisional licensee whose assisted living facility license has been extended with conditions may request reconsideration by the commissioner. The reconsideration request will be processed internally by the commissioner, and chapter 14 does not apply. You must submit the request for reconsideration within 15 calendar days of the date of this letter. To submit a request for reconsideration, please visit:
https://forms.web.health.state.mn.us/form/HRD-Appeals-Form

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 Jessie Chenze directly at: 218-332-5175.

Sincerely,

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

PMB

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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: SL39587015-0 On March 4, 2024, through March 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one resident; one receiving services under the provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 180 SS=F	144G.16 Subd. 2 Initial survey (a) During the provisional license period, the commissioner shall survey the provisional	0 180		

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0 180	Continued From page 1 licensee after the commissioner is notified or has evidence that the provisional licensee is providing assisted living services to at least one resident. (b) Within two days of beginning to provide assisted living services, the provisional licensee must provide notice to the commissioner that it is providing assisted living services by sending an e-mail to the e-mail address provided by the commissioner. (c) If the provisional licensee does not provide services during the provisional license period, the provisional license shall expire at the end of the period and the applicant must reapply. (d) If the provisional licensee notifies the commissioner that the licensee is providing assisted living services within 45 calendar days prior to expiration of the provisional license, the commissioner may extend the provisional license for up to 60 calendar days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Minnesota Department of Health (MDH) within two days of starting services. This had the potential to affect all residents residing at 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, 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).	0 180		

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0 180	Continued From page 2 The findings include: The licensee was issued their provisional assisted living license on February 16, 2023. R2 admitted and assisted living services were first provided on November 22, 2023, and discharged on December 1, 2023. R1 admitted and assisted living services were first provided on November 27, 2023. The Notice of Providing Assisted Living Services form submitted to MDH noted assisted living services started on November 27, 2023, and they had one resident listed as R1. On March 4, 2024, at 12:35 p.m., unlicensed personnel/manager (ULP/M)-C stated the original notice of providing services was sent to MDH on November 30, 2023, and a reply was received on December 1, 2023. ULP/M-C stated she did not notify MDH when R2 admitted to the facility since they were unable to get the contract or service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 180		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the	0 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: ______ B. WING ______	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	**11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448**

(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
0 460	Continued From page 3	0 460		

assisted living contract;
(7) permit residents access to food at any time;
(8) allow residents to choose the resident's visitors and times of visits;
(9) allow the resident the right to choose a roommate if sharing a unit;
(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee lacked a system for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week for one of one resident (R1). This had the potential to affect all residents residing at 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, 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:

The licensee had a provisional Assisted Living license effective February 16, 2023, and was licensed for a bed capacity of five residents.

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0 460	Continued From page 4	0 460		

During the entrance conference on March 4, 2024, at 9:50 a.m., unlicensed personnel/manager (ULP/M)-C and ULP/assisted living director in residency (ULP/ALDIR)-B stated the facility did not have a call system in place for residents to request assistance when needed. ULP/M-C stated staff were always around R1, except this week when he has been spending more time in his room, and added R1 would come out and ask if he needed something.

During the initial tour of the facility with ULP/M-C on March 4, 2024, at 10:30 a.m., the surveyor observed the facility consisted of a single family style home, with two levels. The lower level consisted of two bedrooms, a bathroom, an office, and a common area with a television and fireplace. The upper level consisted of three bedrooms, two bathrooms, a living room, dining room, and kitchen. ULP/M-C stated the current census was one. In addition, the surveyor observed no bells, call lights, or pendants in resident rooms or worn by the resident. R1 resided in a bedroom on the upper level with a private bathroom.

The licensee's Staffing policy dated February 16, 2023, noted residents were provided with a means to request assistance for health and safety needs 24 hours per day, seven days per week.

No further information was provided.

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

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0 470	Continued From page 5	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing schedule was posted with the required content. This had the potential to affect the licensee's current resident, staff, and any visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 6	0 470		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The licensee held a provisional Assisted Living license issued on February 16, 2023, was licensed for a capacity of five residents, and at the time of the survey had a census of one resident.

During the entrance conference on March 4, 2024, at 9:50 a.m., unlicensed personnel/manager (ULP/M)-C and ULP/assisted living director in residency (ULP/ALDIR)-B stated the licensee had three shifts Monday through Friday, with one ULP working each shift, and Saturday and Sunday two shifts with one ULP working each shift.

During the initial tour of the facility with ULP/M-C on March 4, 2024, at 10:30 a.m., the surveyor observed a white board in the opened closet area just inside the main entrance. The board contained the days of the week, and the names of two staff working each day. It also included the name and telephone numbers of ULP/ALDIR-B and clinical nurse supervisor (CNS)-A.

On March 4, 2024, at 1:24 p.m., ULP/M-C stated the posting did not have the required content. She stated she had a different one up before with staff phone numbers but someone told her she could not have the phone numbers so it was

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0 470	Continued From page 7 changed to this format. In addition, ULP/M-C stated ULP/ALDIR-B worked the night shift most nights and was not included on this posting. ULP/M-C said the posting also lacked the hours worked. The licensee's Facility Staffing Plan dated November 22, 2023, noted Monday through Friday would have three shifts with one ULP per shift, and Saturday and Sunday would have two shifts with one ULP per shift. The licensee's Staffing policy dated February 16, 2023, noted a daily staffing schedule was prepared by the CNS to address the work schedules for each ULP showing all work shifts with the days and hours work, and include the assignment or work location. It noted the schedule was posted at the beginning of the shift in a central location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the 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	0 480		

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0 480	Continued From page 8 prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in	0 485		

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menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and
(C) the facility cannot require a resident to include and pay for meals in their contract;
(ii) weekly housekeeping;
(iii) weekly laundry service;

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 require any resident to include and pay for meals as a part of their assisted living package fee. In addition, the licensee failed to provide or make available a menu at least one week in advance. This had the potential to affect all residents of the facility.

This practice resulted in a level one violation (a violation that has no 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 the residents).

The findings include:

The licensee's Assisted Living Contract noted on page 3, "Subject to the Resident's needs, [licensee's name] will provide the following services which are included in the basic monthly fee:" Section 1. Food Service: Three meals/day are serviced in the dining area as planned and prepared by staff.

On March 4, 2024, at 2:35 p.m., unlicensed

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0 485	Continued From page 10 personnel/manager (ULP/M)-C stated residents did not have the option of other than all meals at this point. ULP/M-C later provided an attachment to the contract which was available to have choices on no meals, one meal, two meals, or all three meals. However, they were not aware of this previously and it had not been utilized. In addition, ULP/M-C stated assisted living director in residency (ULP/ALDIR)-B prepared the menus on Thursdays for the following week, so a menu was not available at least one week in advance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity	0 580		

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0 580	Continued From page 11	0 580		

appropriate to the size and relevant to the type of services provided by the assisted living facility. This had the potential to affect the licensee's current resident.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on March 4, 2024, at 9:50 a.m., unlicensed personnel/manager (ULP/M)-C stated they had a binder for quality management and would review if they had any incidents or complaints, but have not had any yet. ULP/M-C added there were no current topics being worked on.

The licensee's Quality Improvement policy dated February 16, 2023, noted the licensee had established a quality improvement program based on the size and appropriate to the type of services provided in order to assure effective, comprehensive, and appropriate plans were operational for all residents.

No further information was provided.

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

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0 650	Continued From page 12	0 650		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for three of three employees (unlicensed personnel/assisted living director in residency (ULP/ALDIR)-B, clinical nurse supervisor (CNS)-A, ULP/manager (ULP/M)-C). 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	0 650		

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0 650	Continued From page 13	0 650		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

ULP/ALDIR-B
ULP/ALDIR-B had a hire date of November 22, 2022, to provide direct care and services to the licensee's residents.

ULP/ALDIR-B's employee record lacked documented evidence of the following:
- records of orientation to include a review of the licensee's policies and procedures;
- review of the types of Assisted Living services the employee would provide and the provider's scope of license;
- principles of person-centered planning and service delivery; and
- records of training and competency evaluations under statute 144G.61 Subd. 2(a) and Subd. 2(b).

CNS-A
CNS-A had a hire date of May 18, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees.

CNS-A's employee record lacked documented evidence of the following:
- a current job description to include identification of staff persons providing supervision; and
- records of orientation to include a review of the licensee's policies and procedures.

ULP/M-C

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0 650	Continued From page 14 ULP/M-C had a hire date of November 22, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. ULP/M-C's employee record lacked documented evidence of the following: - records of orientation to include a review of the licensee's policies and procedures; - principles of person-centered planning and service delivery; and - records of training and competency evaluations under statute 144G.61 Subd. 2(a) and Subd. 2(b). On March 5, 2024, at 1:55 p.m., ULP/ALDIR-B stated all staff completed the training and competency testing with CNS-A before any services were provided to residents. ULP/M-C stated she entered dates into the electronic record incorrectly under the supervision and deleted the paperwork completed for the training and competency testing done, so the employee records lacked the required documented evidence. The licensee's Personnel Records policy dated February 16, 2023, noted the personnel record for each employee would include documentation of orientation and a signed job description. The licensee's Staff Orientation and Education policy dated February 16, 2023, noted the licensee would maintain proof of orientation and education in the personnel files. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 660	Continued From page 15	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of a completed health history and symptom screening for three of three employees (unlicensed personnel/assisted living director in residency (ULP/ALDIR)-B, clinical nurse supervisor (CNS)-A, ULP/manager (ULP/M)-C) and completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of three employees (ULP/ALDIR-B). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 660		

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0 660	Continued From page 16 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated February 16, 2023, indicated the licensee was a low risk for transmission of TB. ULP/ALDIR-B ULP/ALDIR-B had a hire date of November 22, 2022, to provide direct care and services to the licensee's residents. ULP/ALDIR-B's employee record lacked evidence of a health history and symptom screening and completion of a two-step TST or other evidence of TB screening. CNS-A CNS-A had a hire date of May 18, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. CNS-A's employee record lacked evidence of a health and history and symptom screening. ULP/M-C ULP/M-C had a hire date of November 22, 2022, to provide direct care and services to the licensee's residents and oversight of the licensee's employees.	0 660		

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	39587	A. BUILDING: ____ B. WING ____	03/06/2024

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0 660	Continued From page 17 ULP/M-C's employee record lacked evidence of a health and history and symptom screening. On March 5, 2024, at 1:28 p.m., ULP/M-C stated the history and symptom screening had not been completed for any of the licensee's employees, and stated she thought this was done with the testing. On March 6, 2024, at 8:30 a.m., ULP/M-C stated ULP/ALDIR-B had sent the results of his TB testing to her via phone, but she had deleted it by accident. ULP/M-C stated she would reach out to ULP/ALDIR-B to resend the copy, but no further information was received. The licensee's Tuberculosis, Employee Screening For policy, effective January 2023, indicated all employees were screened for latent tuberculosis infection (LTBI) and active TB disease using TST, interferon gamma release assay (IGRA) (blood test for TB), and symptom screening, prior to beginning employment. The policy incorrectly directs, "If the baseline test is negative and the individual risk assessment indicates no risk factors for acquiring TB, then no additional screening is indicated," and, "If the baseline test is positive, but the individual risk assessment is negative and the individual is asymptomatic, a second test (either TST or IGRA) is conducted." Also included, "The Employee Health Coordinator (or designee) will accept documented verification of TST or IGRA results within the preceding 90 days." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated Baseline TB screening consists of three	0 660		

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0 660	Continued From page 18 components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. Also included, an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 680		

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0 680	Continued From page 19	0 680		

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 have a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect all current 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 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 the initial tour of the facility with unlicensed personnel/manager (ULP/M)-C on March 4, 2024, at 10:30 a.m., the surveyor observed the facility consisted of a single family style home, with two levels. The lower level consisted of two bedrooms, a bathroom, an office, and a common area with a television and fireplace. The upper

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0 680	Continued From page 20 level consisted of three bedrooms, two bathrooms, a living room, dining room, and kitchen. ULP/M-C stated the current census was one. In addition, the surveyor observed no bells, call lights, or pendants in resident rooms or worn by the resident. R1 resided in a bedroom on the upper level with a private bathroom. The licensee's Emergency Preparedness Manual dated reviewed February 16, 2024, included a Hazard Vulnerability Assessment (HVA) dated February 15, 2024, which identified the probability of individualized events, but lacked identification of the level of vulnerability or the preparedness for the events. The manual lacked: - policy and procedure for alternate sources of energy to maintain safe and sanitary storage of provisions; - policy and procedure to track the location of staff whether evacuated or sheltered in place; - policy and procedure to address the system of medical documentation that preserved resident information, protected confidentiality, and secured/maintained availability of records; - communication plan to include the names and contact information of residents' physicians; - means of providing information about the general condition/location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4); and - participation in two exercises per year to test the EP, including unannounced staff drills. On March 6, 2024, at 10:42 a.m., ULP/M-C stated she thought the HVA only required the first section to be completed, and stated they needed to update the plan to include the required policies and procedures. ULP/M-C stated they had not conducted any drills other than the fire drill to include a fire in the kitchen.	0 680		

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0 680	Continued From page 21 Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. 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	0 780		

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0 780	Continued From page 22 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 functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 05, 2024, at 9:45 a.m., survey staff toured the facility with unlicensed personnel/ manager (ULP/M)-C. Survey staff tested the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected and the lower level did not have any smoke alarms installed. These deficient conditions were visually verified by ULP/M-C accompanying on the tour.	0 780		

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0 780	Continued From page 23 During interview, on March 05, 2024, at 1:30 p.m. ULP/M-C stated they understood the smoke alarm requirements and would figure out how to get them interconnected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN Statute. This had the potential to affect all current 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	0 790		

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0 790	Continued From page 24 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 March 05, 2024, at 9:45 a.m., survey staff toured the facility with unlicensed personnel/ manager (ULP/M)-C. It was observed that the portable fire extinguishers were not tagged showing the required annual service date and also lacked the records to show the required monthly visual inspections to date. During interview on March 05, 2024, at 1:30 p.m. survey staff explained to ULP/M-C that the portable fire extinguishers must be provided annual certification tags and also with monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location with no obvious physical damage or condition to the extinguisher to prevent their operation when needed. ULP/M-C stated that they did not know a monthly inspection was required and stated that they had purchased the fire extinguishers in 2023 but did not have a receipt. ULP/M-C acknowledged the deficiency and stated they would start completing the monthly visual inspections and annual certification. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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0 800	Continued From page 25	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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, 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 March 05, 2024, at 9:45 a.m., survey staff toured the facility with unlicensed personnel/ manager (ULP/M)-C. It was observed that the outlet cover in bedroom #5 near the window was	0 800		

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0 800	Continued From page 26 broken and missing a portion of the cover plate which exposed the j-box and wiring to the room. It was observed that the back of the house had two holes in the siding which would allow pests and water behind the siding and into the structure of the building. The garage had a small hole in the foundation wall and the stone veneer was pulling away from the sheathing at the corner of the garage. The sheathing behind the stone veneer has signs of water damage and heavy weathering. The exterior envelope of the building must be maintained in good condition to ensure a safe living environment. It was observed that the upstairs living room ceiling had cracking and potential water damage along the sides of each of the beams and at the ridge over the kitchen. The areas with damage had been recently painted to cover or hide any discoloration or staining from previous water damage. ULP/M-C stated they had not known about the cracking and also stated that the painting had been completed prior to them taking responsibility for the property and opening the facility. It was observed that the en suite bathroom in bedroom #1 had water damage by the shower. There were broken tiles on the floor, tiles falling off the wall base, and paint wrinkled and chipping away from the wall exposing damaged drywall near the floor. It was observed in unoccupied bedrooms #2 and #3 that the window hardware was not properly maintained and was obstructing the window from opening completely to allow for egress. Egress windows must be provided and properly maintained in buildings not equipped with an	0 800		

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0 800	Continued From page 27 automatic sprinkler system. ULP/M-C visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 28 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on March 05, 2024, at 9:45 a.m., the surveyor observed the fire evacuation diagrams did not have room numbers associated with the bedrooms. On March 05, 2024, unlicensed personnel/ manager (ULP/M)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated February 16, 2023, failed to include the following:	0 810		

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0 810	Continued From page 29 The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but failed to include procedures for how staff are to complete each step. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on March 05, 2024, at 1:30 p.m., ULP/M-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any	0 900		

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0 900	Continued From page 30 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 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 execute a written contract prior to providing assisted living services for one of two residents (R2). In addition, the licensee failed to provide a complete copy of the contract to the Office of Ombudsman for Long-Term Care (OOLTC).	0 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: ______ B. WING ______	03/06/2024

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0 900	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's Service Plan dated November 22, 2023, noted services including assistance with activities of daily living and medication administration. R2's Assisted Living Contract dated November 22, 2023, was signed by the facility, but lacked a signature by R2. On May 5, 2024, at 2:30 p.m., unlicensed personnel/manager (ULP/M)-C stated a copy of the blank contract had not been sent to OOLTC, and she was not aware of the requirement to do so. In addition, ULP/M-C stated R2 was unresponsive during his stay at the facility, and had no legal representative, so a signature was not obtained for his documents. ULP/M-C stated they had been working with the county to find a person to sign. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous	0 910		

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0 910	Continued From page 32	0 910		

Continued From page 32

place and manner on the contract the legal name and the health facility identification of the facility.
(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:
(1) the facility and contracted service provider when applicable;
(2) the licensee of the facility;
(3) the managing agent of the facility, if applicable; and
(4) the authorized agent for the facility.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2).

This practice resulted in a level one violation (a violation that has no 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 the residents).

The findings include:

R1
R1's Service Plan dated November 27, 2023, noted services including verbal reminders for treatments and assistance with laundry.

R1's Assisted Living Contract was dated November 27, 2023. The contract included the incorrect health facility identification (HFID) number.

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0 910	Continued From page 33 R2 R2's Service Plan dated November 22, 2023, noted services including assistance with activities of daily living and medication administration. R2's Assisted Living Contract was dated November 22, 2023. The contract included the incorrect HFID number. On March 5, 2024, at 2:30 p.m., unlicensed personnel/manager (ULP/M)-C stated the incorrect number was placed on the contract and the same contract template was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of	0 930		

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0 930	Continued From page 34	0 930		

Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;
(4) the resident's right to obtain services from an unaffiliated service provider;

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2).

This practice resulted in a level one violation (a violation that has no 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 the residents).

The findings include:

R1
R1's Service Plan dated November 27, 2023, noted services including verbal reminders for treatments and assistance with laundry.

R1's Assisted Living Contract dated November 27, 2023, noted on page 9 under section titled Term and Termination "Refer also to Discharge and Transfer of Residents and the Nonrenewal of Housing, Service Reduction and Planned Closure policies."

R2
R2's Service Plan dated November 22, 2023, noted services including assistance with activities

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0 930	Continued From page 35 of daily living and medication administration. R2's Assisted Living Contract was dated November 22, 2023, noted on page 9 under section titled Term and Termination "Refer also to Discharge and Transfer of Residents and the Nonrenewal of Housing, Service Reduction and Planned Closure policies." On March 5, 2024, at 2:30 p.m., unlicensed personnel/manager (ULP/M)-C stated the discharge and transfer of residents and the nonrenewal of housing, service reduction and planned closure policies were not reviewed or provided to residents. In addition, ULP/M-C stated the same contract template was utilized for all residents, and therefore the required content was not provided to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working	01530		

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01530	Continued From page 36 hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel/assisted living director in residency (ULP/ALDIR)-B) received the required training on the required topics specified under paragraph (b) related to dementia training. 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: ULP/ALDIR-B had a hire date of November 22, 2022, to provide direct care and services to the licensee's residents.	01530		

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01530	Continued From page 37 ULP/ALDIR-B's transcript lacked evidence of completing all areas of required dementia training to include person-centered planning and service delivery. On March 5, 2024, at 2:10 p.m., ULP/manager (ULP/M)-C) stated she was not sure why this portion was not done for ULP/ALDIR-B and said it should be a part of the initial training. The licensee's Dementia Education policy dated February 16, 2023, noted training topics would include person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services for one of one resident (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:

During the entrance conference on March 4, 2024, at 9:50 a.m., clinical nurse supervisor (CNS)-A stated reassessments are done 14 days after initiation of services, every 90 days, and with a change in condition.

R1 admitted on November 27, 2023, and received services under the licensee's assisted living license.

R1's diagnoses included alcohol dependence and

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01620	Continued From page 39 Barrett's esophagus without dysphasia. R1's Service Plan dated November 27, 2023, noted services including verbal reminders for treatments and assistance with laundry. R1's Nurse Reassessment Visit, identified as the 14-day visit, was dated December 20, 2023, 23 days after the initiation of services. On March 5, 2024, at 9:55 a.m., CNS-A stated he was aware of the requirement to complete the assessment 14 days after initiation of services, but sometimes when he came, the resident was not available. CNS-A stated he did not make notes of attempts to complete the assessment when R1 was not available. The licensee's Assessment and Reassessment policy dated February 16, 2023, noted the registered nurse would provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting	01640		

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agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.
(c) The facility must implement and provide all services required by the current service plan.
(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.
(e) Staff providing services must be informed of the current written service plan.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of two residents (R2), and failed to ensure the service plan was revised to reflect the current services provided for one of one 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:

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R2
R2 admitted to the facility on November 22, 2023, and discharged on December 1, 2023.

R2's diagnoses included constipation and anxiety.

R2's Service Plan dated November 22, 2023, noted services including assistance with activities of daily living and medication administration. However, the service plan lacked a signature by the resident or resident's representative or other authentication documenting agreements on the services to be provided.

On March 4, 2024, at 1:40 p.m., unlicensed personnel/manager (ULP/M)-C stated R2 was unresponsive during his stay at the facility, and had no legal representative, so a signature was not obtained for his documents. ULP/M-C stated they had been working with the county to find a person to sign.

R1
R1's diagnoses included alcohol dependence and Barrett's esophagus without dysphasia.

R1's Service Plan dated November 27, 2023, noted services including verbal reminders for treatments and assistance with laundry. However, the service plan lacked identification of medication administration.

R1's prescriber orders dated February 23, 2024, included one antidepressant / nerve pain medication.

R1's March Med (Medication) Admin (Administration) Summary for March 2024, indicated R1 had refused his medication March 1, 2024, through March 5, 2024.

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01640	Continued From page 42 On March 5, 2024, at 9:55 a.m., ULP/M-C stated the service plan had not been updated to include the medication management when ordered and got missed. The licensee's Service Plan policy dated February 16, 2023, noted the initial service plan and any revisions would be signed by the licensee and the resident or resident's representative to indicate agreement on the services to be provided, and must be revised based on the resident reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650		

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01650	Continued From page 43 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 interview and record review, the licensee failed to ensure a service plan included the required content for one of one resident (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 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: R1's diagnoses included alcohol dependence and Barrett's esophagus without dysphasia. R1's Service Plan dated November 27, 2023, noted services including verbal reminders for treatments and assistance with laundry. However, the service plan lacked: - fees for services; - the schedule and methods of monitoring assessments of the resident;	01650		

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01650	Continued From page 44 - a contingency plan including: - information as to who had the authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services were not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On March 5, 2024, at 9:55 a.m., unlicensed personnel/manager (ULP/M)-C stated the service plan lacked the required content, and this would be fixed once they started using the service plan through the electronic record system. In addition, ULP/M-C stated the same service plan template was utilized for all residents. The licensee's Service Plan policy dated February 16, 2023, noted the service plan would include the fees for services, the schedule and methods of monitoring reviews or assessments of the resident, and a contingency plan including the identification of and information as to who had the authority to sign for the resident in an emergency, and the circumstances in which emergency medical services were not to be summoned and declarations made by the resident related to the health care directives. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to	01700		

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01700	Continued From page 45 providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R1) who received medication management services. 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	01700		

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01700	Continued From page 46	01700		

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:

During the entrance conference on March 4, 2024, at 9:50 a.m., unlicensed personnel/manager (ULP/M)-C stated the licensee provided medication management services to residents at the facility.

R1's diagnoses included alcohol dependence and Barrett's esophagus without dysphasia.

R1's Service Plan dated November 27, 2023, noted services including verbal reminders for treatments and assistance with laundry.

R1's prescriber orders dated February 23, 2024, included one antidepressant / nerve pain medication.

R1's March Med (Medication) Admin (Administration) Summary for March 2024, indicated R1 had refused his medication March 1, 2024, through March 5, 2024.

R1's Medication Profile dated December 20, 2023, noted medications, purpose, side effects, and interactions. However, it lacked identification of:
- contraindications; and
- interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's

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01700	Continued From page 47 medications and prevent diversion of medications. On March 5, 2024, at 9:55 a.m., clinical nurse supervisor (CNS)-A stated the medication assessment was completed, but lacked the entire required content. CNS-A stated this would be remedied with the start of the electronic medical record system. The licensee's Assessment of Medications policy dated February 16, 2023, noted the assessment would include changes in condition that contraindicate continued administration of the medication and interventions needed in the management of medications by the resident or others with access to it. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of	01730		

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01730	Continued From page 48 diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a current individualized medication management plan to include all required content, and failed to include a written statement in the service plan of the medication management being provided for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730		

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01730	Continued From page 49	01730		

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on March 4, 2024, at 9:50 a.m., unlicensed personnel/manager (ULP/M)-C stated the licensee provided medication management services to residents at the facility.

R1's diagnoses included alcohol dependence and Barrett's esophagus without dysphasia.

R1's Service Plan dated November 27, 2023, noted services including verbal reminders for treatments and assistance with laundry. However, the service plan lacked identification of medication administration.

R1's prescriber orders dated February 23, 2024, included one antidepressant / nerve pain medication.

R1's March Med (Medication) Admin (Administration) Summary for March 2024, indicated R1 had refused his medication March 1, 2024, through March 5, 2024.

R1's record lacked a medication management plan to include:
- a statement describing the medication management services that would be provided;
- a description of storage of medications based on the resident's needs and preferences, risk of

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diversion, and consistent with the manufacturer's directions;
- documentation of specific resident instructions related to the administration of medications;
- identification of persons responsible for monitoring medication supplies and ensuring medication refills were ordered on a timely basis;
- identification of medication management tasks that may be delegated to ULP;
- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arose with medication management services; and
- any resident-specific requirements relating to documenting medication administration, verifications that all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

On March 5, 2024, at 9:55 a.m., clinical nurse supervisor (CNS)-A stated R1's record lacked a medication management plan. He stated he was aware of the requirement to have a medication management plan, and to include the medication management in the service plan, but followed what the electronic medical record system gave him.

The licensee's Service Plan for Medication Management policy dated February 16, 2023, noted the licensee would prepare and document a medication management plan as a part of the service plan including a statement describing the medication management services to be provided, a description of the storage of medications, documentation procedures, identification of persons responsible for monitoring medication supplies and refills, description of medication management tasks to be delegated to ULP, plans

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01730	Continued From page 51 for staff to notify the licensed health professional with a medication management problem, and any resident-specific requirements related to documenting medication administration, verification that all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and	01790		

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01790	Continued From page 52 (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01790		

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(RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on March 4, 2024, at 9:50 a.m., unlicensed personnel/manager (ULP/M)-C stated the licensee provided medication management services to residents at the facility.

The licensee's Medication Management Plan for Residents Away from Home policy and procedure dated February 16, 2023, noted for unplanned times away from home for temporary periods when an adequate medication supply could not be obtained from the pharmacy or setup by the RN, the RN may delegate to the ULP if the RN had developed written procedures/ protocols including the type of container to be used, how the container should be labeled, written information to be provided about the medication, documentation requirements including the date, who received the medications, who provided the medications, the number of medications provided, and how the RN should be notified that the medications were provided and whether the

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01790	Continued From page 54 RN should be notified before the medications were given to the resident or designated representative. However, the policy lacked the following: - how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative. On March 6, 2024, at 9:50 a.m., ULP/M-C stated information on when to notify the nurse was missed in the procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of one resident (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	01820		

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01820	Continued From page 55	01820		

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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 March 4, 2024, at 9:50 a.m., unlicensed personnel/manager (ULP/M)-C stated the licensee provided medication management services to residents at the facility.

R1's record lacked an order for Vitamin D2.

R1's diagnoses included alcohol dependence and Barrett's esophagus without dysphasia.

R1's Service Plan dated November 27, 2023, noted services including verbal reminders for treatments and assistance with laundry.

R1's Medication Administration Record (MAR) for January 2024 included the following, and included staff initials January 2, 2024, January 9, 2024, and January 16, 2024, indicating the medication had been administered.
- Vitamin D2 50,000 international units, take one capsule by mouth one time daily for 12 weeks.

On March 5, 2024, at 9:55 a.m., clinical nurse supervisor (CNS)-A stated there was no order for Vitamin D2. CNS-A stated he had transcribed the order from the bottle of medication. In addition, CNS-A stated there should be a prescriber's order for all medications.

The licensee's Prescriber's Orders policy dated February 16, 2023, noted written orders would be obtained from an authorized prescriber for all

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01820	Continued From page 56 medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	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: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of one medication storage cabinet. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 4, 2024, at 9:50 a.m., unlicensed personnel/manager (ULP/M)-C stated the licensee provided medication management	01880		

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services to residents at the facility.

During the initial tour on March 4, 2024, at 10:30 a.m., the surveyor observed the medication cabinet inside the staff office on the lower level with ULP/M-C. The cabinet had a key in the lock. When leaving the office, ULP/M-C stated there was a sign on the office door that said staff only, and left the door ajar while completing the tour.

Throughout the survey, the office door was observed to be left open when staff were in and out of the office. The keys remained in the medication cabinet, which was visible from the doorway.

On March 5, 2024, at 9:40 a.m., clinical nurse supervisor (CNS)-A stated the medication cabinet should remained locked at all times when not in use, and the keys removed.

The licensee's Storage / Control of Medications policy dated February 16, 2023, noted when the licensee provided medication storage outside the resident's private living space, all medications would be securely locked in substantially constructed compartments, and only authorized personnel would have access to the stored medications.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01910
SS=F

144G.71 Subd. 22 Disposition of medications

(a) Any current medications being managed by the assisted living facility must be provided to the

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01910	Continued From page 58 resident when the resident's service plan ends or medication management services are no longer 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 (R2) 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 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:	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: ______ B. WING ______	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

(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 59	01910		

During the entrance conference on March 4, 2024, at 9:50 a.m., unlicensed personnel/manager (ULP/M)-C stated the licensee provided medication management services to residents at the facility.

R2 admitted to the facility on November 22, 2023, and discharged on December 1, 2023.

R2's diagnoses included constipation and anxiety.

R2's Service Plan dated November 22, 2023, noted services including assistance with activities of daily living and medication administration.

R2's prescriber orders dated November 27, 2023, included morphine 1.5 milliliters (ml) every four hours as needed for pain or shortness of breath, and lorazepam 0.5 ml every four hours for anxiety.

R2's Progress Notes dated December 1, 2023, by clinical nurse supervisor (CNS)-A indicated "resident passed away" and noted the hospice nurse destroyed all controlled medications.

R2's December 2023 untitled medication administration record noted R2 received the following medications:
- lorazepam 0.5 ml by mouth every four hours for anxiety; and
- morphine 0.5 ml every four hours for pain / shortness of breath.

R2's record lacked documentation of the disposition of medications to include the medication name, strength, prescription number as applicable, quantity, and the names of staff and other individuals involved in the disposition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39587	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

(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 60 On March 5, 2024, at 9:45 a.m., CNS-A stated he was aware of the requirement to document the disposition of medications, but by the time he arrived to the facility after the resident had passed away, they were already destroyed by the hospice nurse. The licensee's Disposition and Disposal of Medications policy dated February 16, 2023, noted upon disposition, the licensee would document the name, strength, prescription number, quantity, method of disposition or to whom the medications were given, the date of disposition, and the names and signatures of staff or other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: ______ B. WING ______	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

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02240	Continued From page 61	02240		

facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."
(c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint.
(d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a written acknowledgement of receipt of the current assisted living bill of rights was obtained for one of one resident (R1).

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: ______ B. WING ______	03/06/2024

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02240	Continued From page 62 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 the residents). The findings include: R1 was admitted for services on November 27, 2023. R1's diagnoses included alcohol dependence and Barrett's esophagus without dysphasia. R1's Service Plan dated November 27, 2023, noted services including verbal reminders for treatments and assistance with laundry. R1's Assisted Living Contract was signed on November 27, 2023. R1's record lacked written acknowledgement that he received the current Minnesota Bill of Rights for Assisted Living Residents, as required. On March 5, 2024, at 9:55 a.m., unlicensed personnel/manager (ULP/M)-C) stated the Bill of Rights had been provided on admission, but she somehow had missed having any of the residents sign the addendum paperwork acknowledging the receipt. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: ___ B. WING ___	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

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03090	Continued From page 63 (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, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents in the assisted living facility, staff, and any visitors of the licensee. 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 the residents). The findings include: During the initial tour of the facility with unlicensed personnel/manager (ULP/M)-C on March 4, 2024, at 10:30 a.m., the surveyor observed the facility which consisted of a single family style home with two levels. On the outside of the main entrance door, a sign was posted that noted "Warning these premises protected by video surveillance." On March 4, 2024, at 1:40 p.m., ULP/M-C stated	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39587	A. BUILDING: ____ B. WING ____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKELAND HEALTH SERVICES LLC	11840 FOLEY BOULEVARD NW COON RAPIDS, MN 55448

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03090	Continued From page 64 she was not aware the posting needed to include the exact statement with the statutory language. The licensee's Electronic Monitoring policy dated February 16, 2023, noted the licensee would post a sign at each entrance accessible to visitors that noted "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		

MN DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/04/24*
Time: 11:30:00
Report: 1025241043

Food and Beverage Establishment Inspection Report

Location:
LAKELAND HEALTH SERVICES LLC
11840 FOLEY BOULEVARD NW
Coon Rapids, MN55448
Anoka County, 02

Establishment Info:
ID #: 0042471
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities
4-302.12B ***** Priority 2 *****
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
Provide a food thermometer (for food temperatures) as above for the facility
Comply By: 03/08/24

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.
Provide a means of verifying the internal contact temperature during the dish washer sanitizing cycle
Comply By: 03/08/24

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
Operator completed the educational class and reported will be taking proctored exam. Provide evidence of exam completion with application for CPFM (Search MDH CFPM for application and information). Post CFPM certificate when acquired.
Comply By: 03/04/24

Food and Equipment Temperatures

Process/Item: Cottage cheese
Temperature: 34 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

Handles for cabinets clean to sight and touch during inspection, but 1970's ornate style with hollow backs; recommend replacing with cabinet handles that are smooth, durable, and are easy to clean (e.g. like the microwave handle)

Current resident cooks independently with staff supervision; discussed difference between personal items (independently prepared with supervision) vs facility prepared (staff intervention)
Resident hunts as a hobby and has meat prepared by a facility not labeled for resale – maintain as a personal item (reported not to be used by facility, private resident food only)

Labels and marker available for date labeling items on refrigerator door

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher with NSF 184 certification for sanitation
Facility does not have a 3 compartment sink
Facility does not have a dedicated food preparation sink

FACILITY
Kitchen has laminate floor, laminate countertops, stained wood cabinets, hollow enclosed cabinet bases
Appliances are residential

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

Plastic cutting board available

DISHWASHING – NSF 184
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)
Recommend having an alternative means of sanitizing available case of emergency or service interruption

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

Food and Beverage Establishment Inspection Report

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), pest control, quarantine meals

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Chemical label, use, and storage
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page
"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

Food and Beverage Establishment Inspection Report

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

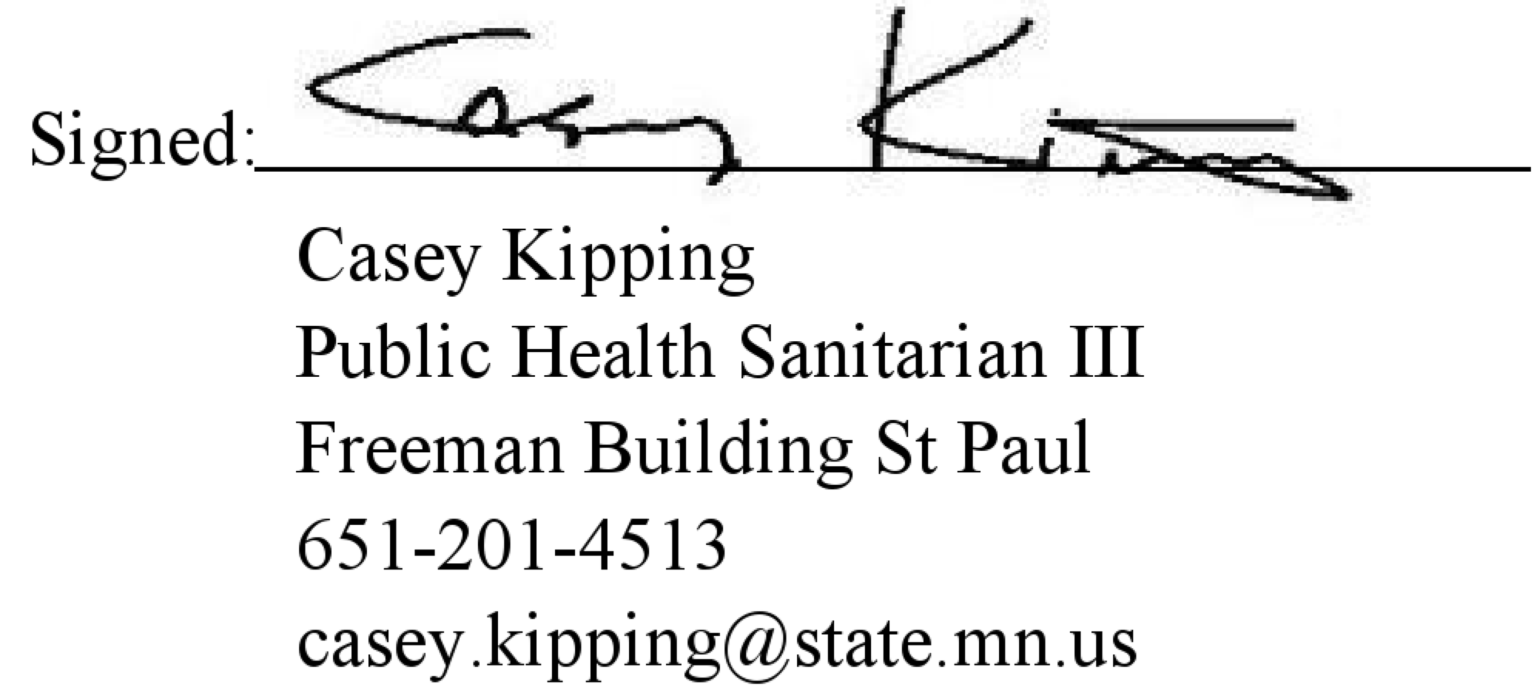
I acknowledge receipt of the Minnesota Department of Health inspection report number 1025241043 of 03/04/24.

Certified Food Protection Manager: TBD

Certification Number: ______________ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:
Urji

Signed: 
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025241043

Food Establishment Inspection Report

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date 03/04/24
No. of Repeat RF/PHI Categories Out	0	Time In 11:30:00
Legal Authority MN Rules Chapter 4626		Time Out

LAKELAND HEALTH SERVICES LLC	Address	City/State	Zip Code	Telephone
	11840 FOLEY BOULEVARD NW	Coon Rapids, MN	55448	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0042471		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

GOOD RETAIL PRACTICES

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

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

Food Recalls:

Person in Charge (Signature) [signature] **Date:** 03/04/24

Inspector (Signature) [signature]