DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 3, 2023

Licensee
Lakeside Manor
4831 London Road
Duluth, MN 55804

RE: Project Number(s) SL30409015

Dear Licensee:

On December 20, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 29, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

Electronically Delivered

October 13, 2022

Administrator
Lakeside Manor
4831 London Road
Duluth, MN 55804

RE: Project Number(s) SL30409015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 29, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

St - 0 - 1330 - 144g.60 Subd. 4 (b) - Unlicensed Personnel - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30638015 On, September 26, 2022, through September 29, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 32 residents receiving services under the provider's Assisted Living license. An immediate correcton order was identified on September 27, 2022, issued for SL#30638015, tag identification 1330. On September 29, 20222, the immediacy of correction order 1330 was removed, however, non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 entrance conference on September 26, 2022, at approximately 9:53 a.m., licensed assisted living director (LALD)-A stated the	0 250		

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0 250	Continued From page 3 licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	0 250		

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0 250	Continued From page 4 conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes	0 250		

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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by LALD-A on May 24, 2022. The licensee had an assisted living license issued on January 1, 2022, with an expiration date of January 1, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (3) infection control practices; (4) medication and treatment management; (5) delegation of tasks by registered nurses or licensed health professionals; (6) supervision of registered nurses and licensed health professionals; and (7) supervision of unlicensed personnel	0 250		

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0 250	Continued From page 6 performing delegated tasks. On September 29, 2022, at approximately 2:37 p.m., LALD-A confirmed the licensee conducted orientation, training, and competency evaluations of staff, and a process for evaluating staff performances, provided medication and treatment management services, followed infection control practices, and supervised ULP performing delegated but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0460, 0470, 0480, 0485, 0490, 0510, 0550, 0580, 0650, 0680, 0790, 0810, 0970, 1060, 1330, 1460, 1530, 1560, 1620, 1890, and 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
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 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	0 460		

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0 460	Continued From page 7 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 failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all 32 residents currently residing in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license and was licensed for a bed capacity of 40 residents. The current census at the facility was 32 residents. During entrance conference on September 26, 2022, at approximately 9:53 a.m., during the entrance conference, licensed assisted living director (LALD)-A and registered nurse (RN)-B	0 460		

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0 460	Continued From page 8 confirmed the facility did not have a system in place for residents to summons staff for assistance. LALD-A stated the licensee provided safety checks for all residents at medication and mealtimes. LALD-A stated the licensee's residents were independent with their mobility and would be able to go let staff know if they needed anything, and there were phones with intercom systems located on each floor of the building. LALD-A and RN-B confirmed if a resident fell in their room and could not get up, the resident would have to yell out to summons staff, or if the resident had a roommate, the roommate could summons staff. LALD-A and RN-B further confirmed the resident would not be found until one of the safety checks. During a tour of the facility on September 26, 2022, at approximately 11:09 a.m., with RN-B no system was observed in place for residents to summons staff for assistance. No other information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
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	0 470		

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0 470	Continued From page 9 (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 develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 470		

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0 470	Continued From page 10 The licensee held an assisted living facility license. The facility was licensed for a capacity of 40 and had a current census of 32 residents. During entrance conference on September 26, 2022, at approximately 9:53 a.m., licensed assisted living director (LALD)-A stated the licensee had a staffing plan developed by a registered nurse (RN) and was reviewed every six (6) months. The surveyor requested the licensee's staffing plan to review. During the initial facility tour on September 26, 2022, the surveyor did not observe a posted daily staff schedule available to staff, residents and visitors. On September 27, 2022, at approximately 10:25 p.m., RN-B stated he was unsure if a staffing plan had been developed by the previous RN and further stated the staffing schedule was posted in the medication room and did not post a daily schedule for residents and visitors to be able to access. On September 29, at approximately 1:18 p.m., LALD-A provided the licensee's Direct-Care Staff Plan that was signed by LALD-A on September 26, 2022. The staffing plan did not include: -evidence of any staffing metrics were used to determine appropriate staffing levels; and -evidence the staffing plan was reviewed twice a year. The licensee's undated Direct-Care Staffing Plan signed by LALD-A September 26, 2022, indicated the clinical nurse supervisor would develop and was accountable to implement the staffing plan. The staffing plan would be reviewed, at a minimum, two times a year and the review of the	0 470		

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	30409	A. BUILDING: _____ B. WING _____	09/29/2022

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0 470	Continued From page 11 plan would be documented in the quality meeting minutes. No further information was provided. TIME PERIOD OF 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This 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	0 480		

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0 480	Continued From page 12 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated September 26, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 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 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; (C) the facility cannot require a resident to include and pay for meals in their contract;	0 485		

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0 485	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all 32 residents. 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: During entrance conference on September 26, 2022, at approximately 9:53 a.m., registered nurse (RN)-B stated the menu was posted on the refrigerator in the kitchen and the daily menu was written on a dry erase board in the dining room and updated daily. During the initial facility tour on September 26, 2022, at approximately 11:09 a.m., RN-B confirmed weekly menus were not posted in the dining or main areas of the facility and the only menu posted was the daily menu which was written on the dry erase board in the dining room. On September 26, 2022, at approximately 12:14 p.m., cook-(C) stated the menu rotated every nine (9) weeks and confirmed menus were not provided to the residents and was unaware of the requirement.	0 485		

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0 485	Continued From page 14 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and	0 490		

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0 490	Continued From page 15 psychosocial needs. This had the potential to affect all seven 32 residents residing in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on September 26, 2022, at approximately 9:42 a.m., licensed assisted living director (LALD)-A confirmed the licensee had not developed or implemented a daily activity program. LALD-A stated staff and the house coordinator provided activities for residents; however, the activities were not scheduled daily. On September 26, 2022, at approximately 11:09 a.m., during a tour of the facility with registered nurse (RN)-B, no recreation or daily program of social activities was observed posted in the common area of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 16 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control and current recommendation for COVID-19 regarding wearing appropriate personal protective equipment (PPE). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). On September 26, 2022, at approximately 9:12 a.m., the surveyor was met in the parking lot by registered nurse (RN)-B and was informed two residents were in isolation due to being COVID-19 positive. The surveyor, licensed assisted living director (LALD)-A, and RN-B met in a separate building on the assisted living	0 510		

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0 510	Continued From page 17 premises identified as the "pool house" and conducted the entrance conference. During entrance conference, on September 26, 2022, at approximately 9:53 am, RN-B identified R3 and R8 tested positive for COVID-19 on September 23, 2022, during facility wide testing. LALD-A stated they had been testing employees and residents since September 3 due to a positive COVID-19 case in the assisted living and planned to continue to test until no positive COVID-19 results. LALD-A stated a COVID-19 testing log was being kept with employee and resident testing results. The surveyor requested a copy to review. LALD-A stated they had PPE supplies available and staff were expected to wear gloves, isolation gowns, N95 masks (filtering facepiece respirators), and eye protection if working with a COVID-19 positive resident. RN-B confirmed all residents when outside of their rooms were encouraged to wear surgical masks. VISITOR COVID-19 SCREENING During a tour of the facility on September 26, 2022, at approximately 11:09 a.m., with RN-B, the parking lot entrance of the facility lacked signage posted to inform there was active positive COVID-19 within the facility. Inside the entrance was hand sanitizer and a sign directing not enter building if experiencing symptoms, contact with someone with positive COVID-19, traveled internationally within 14 days, or reside in a community where COVID-19 was occurring. RN-B stated staff self-screened in the medication room for COVID-19 and recorded results were kept in the medication room. COVID-19 ISOLATION	0 510		

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0 510	Continued From page 18 During a tour of the facility on September 26, 2022, at approximately 11:50 a.m., with RN-B, no isolation signage or bins with PPE supplies were observed outside of any of the resident rooms. RN-B stated PPE supplies were kept in the medication room and if staff needed to enter any of the isolation rooms, they would gather the supplies from the medication room, put on gloves, N95 mask and isolation gowns before entering and remove PPE before exiting the room. RN-B stated both R3 and R8 were in private rooms, were independent and staff did not need to enter their rooms. RN-B verified, there were no signs posted outside of the resident rooms who were on isolation. RN-B stated the residents and staff knew who had COVID-19 and were on isolation. On September 28, 2022, at approximately 8:53 a.m., the surveyor observed posted outside of R3's room indicating COVID isolation, required PPE gowns included gloves, eye wear and N95 mask. On September 29, 2022, at approximately 11:54 a.m., RN-B stated he posted the isolation signs outside of R3 and R8's room after the surveyor questioned why signs were not posted to alert staff, residents, and visitors of what PPE was required before entering the room. EYE PROTECTION/CLOTH MASK The Minnesota Department of Health (MDH) guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids dated April 7, 2022, indicated health care workers working with residents with or without suspected or confirmed SARS-CoV-2 (Covid-19) wear a	0 510		

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0 510	Continued From page 19 face mask and eye protection in communities with substantial and high community transmission levels. The MDH document titled, COVID-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 8 that all staff should wear a well-fitting mask and eye protection (e.g. face shield, goggles) when in resident care areas. On September 26, 2022, at approximately 12:14 p.m., ULP-J was observed wearing a cloth mask and eyeglasses in the facility. ULP-J confirmed R3 and R8 tested positive for COVID-19 and were in isolation. ULP-J stated she did not go into the isolation rooms and if she did, she would put on a gown, N95 mask and gloves. On September 26, 2022, at approximately 9:12 a.m. the surveyor observed ULP-E in the medication room administer R4's scheduled morning medications. The surveyor observed ULP-E to be wearing a surgical grade mask and prescription glasses, but no appropriate eye protection. On September 26, 2022, at approximately 12:40 p.m., ULP-D was observed in the medication room wearing a surgical grade mask and not wearing eye protection, administer R3's afternoon scheduled medications. ULP-D prepared R2's medications and wearing gloves and a surgical mask, went to R2's room (COVID-19 positive resident), and knocked on R2's door. R2 opened the door, wearing no mask, ULP-D stood at arms distance, handed R2 a paper cup with medications, ULP-D stepped back from R2's room and observed R2 take his medications. ULP-D removed gloves, washed hands in shared	0 510		

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0 510	Continued From page 20 resident bathroom, proceeded back to the medication room and documented R2 medication administration. ULP-D confirmed she was aware R2 tested positive for COVID-19 and was in isolation. ULP-D stated if entering R2's room, ULP-D would put on an N-95 mask, gloves and a gown. ULP-D stated she did not need to wear eye protection in the facility because she recently had COVID-19. On September 29, 2022, at approximately 12:48 p.m., LALD-A stated he was responsible for keeping up with CDC and MDH (Minnesota Department of Health) COVID-19 recommendations. LALD-A stated in the beginning of the COVID-19 pandemic, he participated in weekly COVID-19 calls and continues to try and keep updated on COVID-19 PPE recommendations. LALD-A confirmed there were no specific COVID-19 policies developed and would post any new guidelines within the facility for staff and residents. LALD-A stated LALD-A and RN-B planned to provide more enforcement to ensure staff were wearing the proper PPE. The licensee had not developed COVID-19 policies. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

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0 550	Continued From page 21 procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. 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) 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 a facility tour on September 26, 2022, at approximately 11:09 a.m., the surveyor observed and confirmed, with registered nurse (RN)-B, the entrance located off the parking lot, had the licensee's grievance procedure posted; however, the grievance procedure posting lacked the required content to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, the grievance procedure lacked the contact information for the	0 550		

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0 550	Continued From page 22 Office of Ombudsman for Mental Health and Developmental Disabilities and the Minnesota Adult Abuse Reporting Center. The licensee's Complaint Policy and Procedure dated August 1, 2021, indicated each resident or resident representative would receive written notice of the facilities process for receiving and resolving complaints. The written notice would include the name and contact information of the person representing the facility designated to handle complaints, the contact information for the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Heath Facility Complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
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	0 580		

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0 580	Continued From page 23 by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living 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), 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 entrance conference on September 26, 2022, at approximately 10:46 a.m., with the licensed assisted living director (LALD)-A and registered nurse (RN)-B, a request was made to review documentation of the licensee's quality management activities. LALD-A stated staff would get together on an informal basis to discuss resident care and confirmed the licensee had not formalized or have documentation of ongoing quality management activities. The licensee's undated Quality Management Plan indicated the Operations Management would develop a continuous quality improvement and management program to maintain the agency's continuous performance improvement efforts, consistent with the current professional standards and the highest quality services for clients. The Quality Council meeting would be held at least semiannually to identify and review dashboard	0 580		

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0 580	Continued From page 24 and other quality measures, set goals and identify changes in procedures or training for staff. Minutes of the meeting would be retained in the agency files for two (2) years and would be made available to the Minnesota Department of Health upon request. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 650 SS=E	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. (b) Each employee record must be retained for at	0 650		

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0 650	Continued From page 25 least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the employee records contained the required content for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-B RN-B had a hire date of March 25, 2022, to provide and supervise direct care services to the licensee's residents. RN-B's employee record lacked the following required content: -a current job description; and -evidence RN-B completed infection control training including tuberculosis. ULP-D	0 650		

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0 650	Continued From page 26 ULP-D had a hire date of August 17, 2021, to provide direct care services for the licensee's residents. On September 26, 2022, at approximately 2:08 p.m., ULP-D was observed administering R2 and R3 their scheduled afternoon medications ULP-D's employee record lacked the following required content: -a current job description; -annual job performance review to include documentation of annual performance review that identified areas of improvement needed and training areas; and -evidence ULP-D completed infection control training including tuberculosis. On September 27, 2022, at approximately 9:15 a.m., RN-B confirmed RN-B and ULP-D's employee records lacked the required content noted above. The licensee's Personnel Records policy revised August 1, 2021, personnel record would include: -record of required in-service education for all staff providing services to clients, including annual training and infection control training; -performance evaluations which identify areas of improvement needed and training needs performance, completed at least annually; and -a current job description, which included qualifications, responsibilities, and identification of supervisors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 680	Continued From page 27	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and 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 and failed to post an emergency preparedness plan prominently. This had the potential to affect all 32 residents, staff and visitors.	0 680		

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0 680	Continued From page 28 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 entrance conference on September 26, 2022, at approximately 9:53 a.m., a request was made to view the licensee's emergency preparedness plan, which was provided and later reviewed by the surveyor. During the facility tour on September 26, 2022, at approximately 11:09 a.m., with registered nurse (RN)-B, the main entrance and common areas lacked signage posted or information regarding the licensee's emergency preparedness plan. On September 27, 2022, at approximately 10:25 a.m., RN-B provided the licensee's undated Disaster/Emergency Plan. The licensee's emergency plan lacked the following: - a completed risk assessment; - process for EP cooperation with state and local EP(emergency preparedness) officials/organizations; - a missing resident plan that was reviewed quarterly (last reviewed July 16, 2014); - a description of the population served by the licensee; - development of policies/procedures to address:	0 680		

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0 680	Continued From page 29 - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal); - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On September 29, 2022, at approximately 12:48 p.m., licensed assisted living director (LALD)-A stated he was responsible for the licensee's Disaster/Emergency plan. LALD-A stated he	0 680		

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0 680	Continued From page 30 thought the current emergency plan met the guidelines in Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). After a brief review of the components required in an emergency preparedness plan, LALD-A confirmed the licensee's current Disaster/Emergency Plan was missing required elements. At approximately, 2:32 p.m., LALD-A stated the missing person policy was reviewed annually with the Disaster/Emergency Plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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 ensure installation and maintenance of portable fire extinguishers at the facility. This had	0 790		

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0 790	Continued From page 31 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 re pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 9/26/2022, from approximately 12:30 PM to 2:00 PM, survey staff toured the facility with LALD-A. During the facility tour, survey staff observed that the fire extinguishers throughout the facility did not have a current inspection tag. The fire extinguishers were last tested in 2020. LALD-A verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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;	0 810		

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0 810	Continued From page 32 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 810		

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0 810	Continued From page 33 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 9/26/2022, from approximately 12:30 PM to 2:00 PM, survey staff requested fire safety training and evacuation plan documentation, but the licensee did not provide the requested documentation.The facility's last fire drill and staff evacuation training was conducted on 12/12/2018. No further infomation provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents.	0 970		

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0 970	Continued From page 34 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: During entrance conference on September 26, 2022, at approximately 9:53 a.m., a copy of the licensee's assisted living contract was requested. The licensee's contract included the following liability language: -Section 29. "Indemnification" of the contract indicated the resident would indemnify and hold harmless the landlord, its employees and agents from and against any and all claims, actions, damages, and liabilities and expenses in connection with loss of life, personal injury or damage to property, arising from or out of the use by tenant of the rented premises or any other part of the landlord's property, or caused wholly or in part by an act or omission of tenant or tenant's guests or agents. -Section 30. "Insurance" of the contract indicated in the event tenant's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered by standard fire and extended coverage insurance, or by other insurance coverage, you hereby waive: (a) all claims against the landlord and its representatives for any such loss or damages; and (b) all rights of subrogation of any insurance	0 970		

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0 970	Continued From page 35 covering such damage or destruction. -Section 33. "Liability" of the contract indicated the landlord is not liable to tenant for any injury, death or property damage occurring in the apartment unit or on the landlord's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by tenant or tenant's guests. Landlord may be liable to tenant for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons, tenant agrees to hold the landlord harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment unit or on the landlord's premises. On September 29, 2022, at approximately 1:00 p.m., licensed assisted living director (LALD)-A confirmed the above noted language was included in the current assisted living contract which indicated the resident's waived the licensee's liability for health, safety, or personal property. LALD-A stated the contract was originally drafted for rental agreement prior to the new assisted living licensing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent	01060		

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01060	Continued From page 36 risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by:	01060		

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01060	Continued From page 37 Based on interview and record review, licensee failed to provide written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one or one resident (R6) reviewed for hospitalizations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During entrance conference on September 26, 2022, at approximately 9:53 a.m., registered nurse (RN)-B confirmed R6 was in the hospital. R6 was admitted for assisted living care services on June 27, 2019. R6's Service Plan dated August 2, 2022, indicated R6 received the following services: medication management, dressing, bathing, housekeeping, and laundry. R6's progress notes dated September 29, 2022, indicated on September 19, 2022, R6 was taken via ambulance to the emergency room, and was admitted for right leg swelling, weakness, and hypoxia (low oxygen levels in the blood). R6's hospital discharge plan was to be discharged on September 29, 2022, to a short term rehabilitation facility.	01060		

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01060	Continued From page 38 R6's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R6's record lacked notification to the Office of Ombudsman for Long-Term Care that the residents had been relocated and had not returned to the facility within four days. On September 29, 2022, at approximately 11:47 a.m., RN-B confirmed a written notice had not been provided with the required content, and the OOLTC had not been notified. RN-B stated he was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01330 SS=I	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and	01330		

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LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

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01330	Continued From page 39 demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff met all requirements for training and competency evaluations, as identified in 144G.60, Subd. 4, and 144G.61 Subd 1. and 2, for three of three unlicensed personnel (ULP-D, ULP-G, ULP-H). This had the potential to affect all residents receiving assisted living services. 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 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). This resulted in an immediate correction order	01330		

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01330	Continued From page 40 identified on September 27, 2022. The findings include: On September 27, 2022, at approximately 10:39 a.m., during entrance conference, licensed assisted living director (LALD)-A confirmed he was responsible for employee hiring, assigning all Educare training (virtual training system), and participated in employee training. ULP-D ULP-D was hired on August 17, 2021, to provide direct care services for the licensee's residents. On September 26, 2022, at approximately 2:08 p.m., ULP-D was observed administering R2 and R3's their scheduled 2 p.m. medications. On September 26, 2022, at approximately 2:17 p.m., ULP-D stated she was trained by other ULPs and LALD-A. ULP-D stated the registered nurse (RN) at the time observed her during a medication pass about a month after she started working and had been passing medications with other ULPs prior to the RN's observation. ULP-D was unsure if she had completed competency evaluations with the RN for other tasks. ULP-D's Staff Supervision Summary indicated ULP-D was supervised on the following tasks by the licensee's RN: -September 27, 2021, on medication administration by a registered nurse (RN); and -September 23, 2022, on insulin, eye drop administration, and crushing medications by RN-B. ULP-D 's employee record included Educare online training transcripts indicating ULP-D	01330		

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01330	Continued From page 41 completed medication administration training on August 18, 2021; however, lacked evidence of demonstrating competency skills tests on all required tasks in accordance with Minnesota Statues Chapter 144G to include: -appropriate and safe technique in personal hygiene and grooming including: hair care and bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting; -standby assistance techniques and how to perform them; -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments; and -other RN professionally delegated tasks (e.g., compression stocking, CPAP, nebulizer and inhalers, oxygen, wound care). ULP-G ULP-G was hired on May 19, 2022, to provide direct care services for the licensee's residents. ULP-G's Staff Supervision Summary dated, June 3, 2022, indicated RN-B trained ULP-G on insulin and eye drop administration and observed ULP-G administer medications. ULP-G's employee record included Educare online training; however, lacked evidence of demonstrating competency skills tests on all required tasks in accordance with Minnesota Statues Chapter 144G to include: -appropriate and safe technique in personal hygiene and grooming including: hair care and bathing, care of teeth, gums and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting; -standby assistance techniques and how to perform them;	01330		

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01330	Continued From page 42 -safe transfer techniques and ambulation; -range of motion and positioning; -administering medications or treatments; and -other RN professionally delegated tasks (e.g., compression stocking, CPAP, nebulizer and inhalers, oxygen, wound care). ULP-H ULP-H was hire on July 12, 2022, to provide direct care services for the licensee's residents. ULP-H's Staff Supervision Summary dated August 12, 2022, indicated RN-B trained ULP-G on insulin and eye drop administration and observed ULP-G administer medications. ULP-H's employee record included Educare online training; however, lacked evidence of demonstrating competency skills tests on all required tasks in accordance with Minnesota Statues Chapter 144G to include: -administering medications via all routes and treatments, as provided by the licensee; and -other RN professionally delegated tasks. On September 26, 2022, at approximately 3:12 p.m., RN-B stated new employees completed Educare's online training before working with residents. RN-B stated new ULPs were trained on the floor by other ULPs and before new employees were able to work independently, RN-B supervised the new employee on vital signs, blood glucose monitoring, medication, and insulin administration. RN-B verified ULP-D's record lacked evidence ULP-D demonstrated competency for required tasks. RN-B verified he had not implemented competency evaluations for new employees since he started working for the licensee in March 2022, and further stated he was unaware of the requirement.	01330		

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01330	Continued From page 43 On September 27, 2022, at approximately 12:30 p.m., ULP-F confirmed she assists with training new employees. ULP-F stated new employees would observe ULP-F working on the floor for a day or two, then ULP-F would supervise the new employee complete an assigned tasks including medication administration and treatments. ULP-F stated before the new employees were able to work independently with medications administration, the RN would need to observe the new employee administer medications. On September 27, 2022, at approximately 12:17 p.m., RN-B stated the ULPs who trained the new employees should not be allowing the new employees to pass medications without the RN providing training and observing the new employee. On September 27, 2022, at approximately 1:05 p.m., licensed assisted living director (LALD)-D verified some of the ULPs had not completed the required competency skills evaluations with the RN prior to performing the tasks. LALD-A stated during the transition when Educare went from DVD training to on line training, the employee's competency evaluations process did not carry over and were not being completed. LALD-A confirmed, himself and other ULPs assisted with employee training on providing cares, treatments, and medication administration. The licensee's Medication Management Services policy dated, July 21, 2014, indicated the RN would assure ULPs were trained, competent and orientated to the client whenever ULPs were to perform medication management services for the client.	01330		

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01330	Continued From page 44 The licensee's Assisted Living Orientation-ULP Staff policy, dated August 1, 2021, indicated training and competency evaluations of ULPs providing assisted living services would be completed by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor's on-site observations and review by evaluations supervisor on September 29, 2022, however, non-complaince remains at a scope and severity of level three, widespread (I).	01330		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees, registered nurse (RN)-B's employee record contained orientation to assisted living facility licensing to include all the required topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01460		

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01460	Continued From page 45 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: RN-B had a hire date of March 25, 2022, to provide and supervise direct care services to the licensee's residents. RN-B's employee record lacked evidence of completing the following assisted living orientation 144G requirement topics before providing assisted living services: - an overview of the 144G statutes; - policies and procedures related to the provision of assisted living services by the individual staff person; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01460		

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01460	Continued From page 46 On September 27, 2022, at approximately 9:15 a.m., RN-B stated he did not complete the orientation to assisted living facility licensing requirements and guidelines. On September 27, 2022, at approximately 12:30 p.m., licensed assisted living director (LALD)-A confirmed RN-B's learning transcript lacked RN-B completed orientation to assisted living facility licensing requirements and guidelines. The licensee's Assisted Living Orientation-All Staff policy dated August 1, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01530 SS=F	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 hours of the employment start date. Until this	01530		

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01530	Continued From page 47 initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-D, ULP-G, and registered nurse (RN)-B) received the required amount of dementia care training in the required time frame with records reviewed. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-B RN-B had a hire date of March 25, 2022, to provide and supervise direct care services to the licensee's residents.	01530		

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01530	Continued From page 48 RN-B's employee record did not indicate a total of 8 hours of the required dementia training was completed within 120 hours of the employee's start date. RN-B's employee record indicated RN-B completed 5 hours of dementia training. ULP-D and ULP-G ULP-D had a hire date of August 17, 2021, to provide direct care services for the licensee's residents. ULP-G had a hire date of May 19, 2022, to provide direct care services for the licensee's residents. On September 26, 2022, at approximately 2:08 p.m., ULP-D was observed administering R2 and R3 their scheduled afternoon medications. ULP-D and ULP-G's employee records did not indicate a total of 8 hours of the required dementia training was completed within 160 hours of the employee's start date. ULP-D and ULP-G's employee records indicated both had completed 5 hours of dementia training. On September 27, 2022, at approximately 9:15 a.m., RN-B confirmed the employee records noted above lacked the required hours of dementia care training. On September 27, 2022, at approximately 12:30 p.m., licensed assisted living director (LALD)-A confirmed RN-B, ULP-D, and ULP-G's training transcripts lacked the initial required eight (8) hours of dementia care training in the required time frame. The licensee's Assisted Living Orientation-All policy date August 1, 2021, indicated staff would	01530		

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01530	Continued From page 49 receive orientation and training on topics required for assisted living organizations including dementia care training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01560 SS=F	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure dementia training included all the required content for three of three employees (unlicensed personnel (ULP)-D, ULP-G), and registered nurse (RN-B). This had the potential to affect all residents.	01560		

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01560	Continued From page 50 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During entrance conference on September 26, 2022, at approximately 9:53 a.m., licensed assisted living director (LALD)-A stated he was responsible for assigning all employee training via EduCare (online training courses). RN-B had a hire date of March 25, 2022, to provide and supervise direct care services to the licensee's residents. ULP-D had a hire date of August 17, 2021, to provide direct care services for the licensee's residents. ULP-G had a hire date of May 19, 2022, to provide direct care services for the licensee's residents. On September 26, 2022, at approximately 2:08 p.m., ULP-D was observed administering R2 and R3 their scheduled afternoon medications. RN-B, ULP-G and ULP-H's employee records lacked evidence they received the following dementia training: - person-centered planning and service delivery. On September 27, 2022, at approximately 9:15	01560		

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01560	Continued From page 51 a.m., RN-B confirmed the employee records noted above did not include person centered planning and service delivery record. On September 27, 2022, at approximately 12:30 p.m., licensed assisted living director (LALD)-A confirmed RN-B, ULP-D, and ULP-G's training transcripts lacked the required dementia training content. LALD-A stated it was his understanding the dementia care EduCare trainings covered all the required initial dementia care training. The licensee's Assisted Living Orientation-All policy date August 1, 2021, indicated staff would receive orientation and training on topics required for assisted living organizations including dementia care training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01620 SS=E	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	01620		

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01620	Continued From page 52 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment not to exceed day 90 for one of three residents (R4). In addition, the RN failed to complete a comprehensive assessment by day 14 from admission for one of three residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4's diagnoses included diabetes, hypertension (high blood pressure), sleep apnea, and chronic obstructive pulmonary disease.	01620		

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LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

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01620	Continued From page 53 R4's Service Plan dated August 1, 2022, indicated R4 received services including medication management, treatment services, assistance with bathing, laundry, and housekeeping. R4's record indicated the RN completed a 90-day assessment on May 12, 2022, and August 11, 2022, which exceeded 90 days from the previous completed assessment by one (1) day. R5 R5's diagnoses included depression, cognitive impairment, hypothyroidism (low thyroid levels), and asthma. R5's Service Plan dated September 1, 2022, indicated R5 received services including medication management, treatment services, bathing reminders, housekeeping and laundry. R5's record indicated the RN completed an initial admission assessment on September 2, 2022, and a 14-day assessment on September 19, 2022, which exceeded 14 days from initial assessment by three (3) days. On September 29, 2022, at approximately 12:09 p.m., RN-B confirmed R4's 90-day assessment and R5's 14-day assessments had not been completed within the required time frame. The licensee's Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy revised August 2021, indicated an RN would complete the following comprehensive nursing assessments as required: - pre-admission; -14 days after start of services;	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 54 -ongoing, no less than every 90-days; and -change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration dates for R2, R5, R6, R12, R13. In addition, the licensee failed to ensure medications were maintained bearing the original prescription label for R13 and further, the licensee failed to monitor for expired medications for R2, R4, R6. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
01890	Continued From page 55 TIME SENSITIVE MEDICATIONS/ORIGINAL PRESCRIPTION LABEL On September 26, 2022, at approximately 11:18 a.m., the surveyor observed the medication cart with registered nurse (RN)-B. RN-B stated it was not their practice to write opened or expiration dates on eye drops, inhalers, or insulins after opened. RN-B confirmed the following: -R2's Albuterol Sulfate inhaler (used to treat chronic obstructive pulmonary disease), lacked a date the inhaler had been opened and when the inhaler would expire. -R5's Symbicort, Ventolin and Spiriva inhalers (used to treat wheezing and shortness of breath) lacked the date the inhalers had been opened and when the inhalers would expire. -R6's Combigan eye drop (medication to treat glaucoma) lacked the date the eye drop was opened or would expire. -R12's opened bottle of latanoprost 0.005% ophthalmic suspension (medication to treat glaucoma) had a label which directed to discard 45 days after opening; however, lacked the date the eye drop had been opened or would expire. -R13's Albuterol, Bevespi Aerosphere inhalers (used to treat chronic obstructive pulmonary disease (COPD), lacked the date the inhalers had been opened and when the inhalers would expire. R13's Anoro Ellipta inhaler (used to treat wheezing and shortness of breath) lacked an original prescription label with the name of the resident, prescriber, and pharmacy, date issued, instructions for use and prescription number. On September 26, 2022, at approximately 11:40 a.m., the surveyor observed the medication refrigerator with RN-B. RN-B stated all opened and unopened insulin pens were stored in the	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
01890	Continued From page 56	01890		

refrigerator and confirmed the following:
-R2's opened Novolog Flex insulin pen (a multiple dose pen shaped injector device for insulin administration) lacked a date the insulin had been opened and when the insulin pen would expire. R2's opened Lantus Solostar insulin pen lacked the date the insulin pen had been opened and when the insulin pen would expire.
-R4's and R11's opened Lantus Solostar insulin pens lacked the dates the insulin pens had been opened and when the insulin pens would expire.
-R9's opened Victoza insulin pen (medication to treat diabetes) lacked the date the insulin pen had been opened and when the insulin pen would expire.
-R10's opened Ozempic pen (non-insulin medication to help lower blood sugar) lacked the date the pen had been opened and when the pen would expire.

The manufacturer instructions for Victoza solution revised August 2017, indicated to throw away any unused medications 30 days after opening Victoza pen.

The manufacturer instructions for Ozempic revised 2022, indicated the medication can stored in the refrigerator for up to eight (8) weeks after opening.

The manufacturer's instructions for Lantus insulin pens dated December 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it.

The manufacturer's instructions for Novolog Flex pen dated June 2021, directed to discard the pen 28 days after opened.

The manufacturer's instructions for Latanoprost

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
01890	Continued From page 57 ophthalmic solution revised August 2011, indicated once the bottle was opened, store at room temperature for up to six weeks. The manufacture instructions for Advair Diskus revised August 2020, directed to throw away 30 days after opening foiled pouch. The manufacturer's instructions for Ventolin/Albuterol inhalers dated 2016, directed to discard the inhaler as soon as the dose counter reaches zero or after the expiration date on the packaging, whichever comes first. You should not keep using the inhaler after 200 sprays even though the canister may not be completely empty. The manufacturer's instructions for Symbicort inhalers dated December 2017, directed to discard the inhaler when the count reaches zero or three (3) months after removal from the foil pouch. EXPIRED MEDICATIONS On September 28, 2022, at approximately 1:57 p.m., the surveyor observed several opened bottles of Gavilax powder on an open bookcase shelf in the medication room. Unlicensed personnel (ULP)-E was unsure who went through the medications looking for expired medications. ULP-E confirmed the following: -R6's Gavilax powder (medication to treat constipation) had expired January 2022; -R14 Gavilax powder had expired July 2022; and -R2's Gavilax powder had expired August 2020. The licensee's Central Storage of Medications policy revised July 21, 2014, indicated medications would be kept in their original	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
01890	Continued From page 58 containers bearing the original prescription label with the prescription number, name of the drug, strength and quantity of the drug, expiration date of a time-dated drug, directions for use, the client's name, the prescriber name, the date of issue, and the name and address of the dispensing pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. 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	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	09/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03090	Continued From page 59 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the initial facility tour on September 26, 2022, at approximately 9:53 a.m., registered nurse (RN)-B verified the current "Notice of Monitoring Activity" sign posted at the entrance from the parking lot lacked the required statutory language for the notice of electronic monitoring. On September 29, 2022, at approximately 12:48 p.m., licensed assisted living director (LALD)-A confirmed the licensee did not have the required signage posted at the main entrances of the building regarding electronic monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/26/22*
Time: 10:30:00
Report: 8010221181

Food and Beverage Establishment Inspection Report

Location:
Lakeside Manor
4831 London Road
Duluth, MN55804
St. Louis County, 69

Establishment Info:
ID #: 0022708
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Lakeside Manor, Inc.

Phone #: 2185252784
ID #: 28593

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

The following orders previously issued on 02/04/20 have NOT been corrected.

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.

THERE WAS NOT A THERMOMETER WITH A SMALL DIAMETER PROBE.

Issued on: 02/04/20 *Comply By: 02/04/20*

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.

THERE WAS NOT AN IRREVERSIBLE REGISTERING TEMPERATURE INDICATOR FOR MEASURING THE UTENSIL SURFACE TEMPERATURE OF THE SANITIZING DISHWASHER.

Issued on: 02/04/20 *Comply By: 02/04/20*

The following orders were issued during this inspection.

2-100 Supervision

2-102.12DMN

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

THE CERTIFIED FOOD PROTECTION MANAGER WAS NOT POSTED.

Comply By: 09/26/22

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: WIPING CLOTH SANITIZER
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: SANITIZING DISHWASHER -TEMP TAPE TURNED BLACK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 193 Degrees Fahrenheit - Location: SAUSAGES
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK-AURORA
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: HAM PORTION-AURORA
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-AURORA
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MARGARINE-AMANA
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: SLICED CHEESE-AMANA
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-AMANA TOP
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-AMANA BOTTOM
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-FRIGIDAIRE
Violation Issued: No

Process/Item: Chest Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

COMMENTS:

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE,

DISCUSSED THE USE OF RAW EGGS THAT ARE ONLY TO BE USED IN ONE RESIDENT'S SERVING AT A SINGLE MEAL IF THE EGGS ARE COMBINED, COOKED AND SERVED IMMEDIATELY OR IN BAKED GOODS THAT ARE THOROUGHLY COOKED IF EGGS ARE COMBINED AS AN INGREDIENT IMMEDIATELY BEFORE BAKING.

DISCUSSED THAT PASTEURIZED EGGS OR EGG PRODUCTS MUST BE SUBSTITUTED FOR RAW EGGS WHEN MORE THAN ONE EGG IS BROKEN, COMBINED AND NOT COOKED, BAKED, OR USED IMMEDIATELY.

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 8010221181 of 09/26/22.

Certified Food Protection Manager: Bart Martinson

Certification Number: FM86319 Expires: 10/25/22

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: _____

Bart Martinson 8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010221181

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	**Date**	09/26/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Lakeside Manor	4831 London Road	Duluth, MN	55804	2185252784

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0022708	Lakeside Manor, Inc.	Full		M

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					COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	IN	(OUT)	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status					COS	R
Time/Temperature Control for Safety							
18	(IN)	OUT	N/A	N/O	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(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

		Safe Food and Water	COS	R
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		X
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	COS	R
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		X
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 09/26/22

Inspector (Signature)

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/19/22*
Time: 10:30:00
Report: 8010221234

Food and Beverage Establishment Inspection Report

Location:
Lakeside Manor
4831 London Road
Duluth, MN55804
St. Louis County, 69

Establishment Info:
ID #: 0022708
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Lakeside Manor, Inc.

Phone #: 2185252784
ID #: 28593

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

No NEW orders were issued during this inspection.

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

COMMENTS:

THIS WAS A FOLLOW UP INSPECTION TO THE INSPECTION DONE ON 09/26/2022.

ALL PREVIOUS ORDERS HAVE BEEN CORRECTED.

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 8010221234 of 12/19/22.

Certified Food Protection Manager: Bart Martinson

Certification Number: FM86319 Expires: 10/26/25

Inspection report reviewed with person in charge and emailed.

Signed: _____ Signed: _____

Bart Martinson 8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010221234

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	**Date**	12/19/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Lakeside Manor	**Address** 4831 London Road	**City/State** Duluth, MN	**Zip Code** 55804	**Telephone** 2185252784
License/Permit # 0022708	**Permit Holder** Lakeside Manor, Inc.	**Purpose of Inspection** Full	**Est Type**	**Risk Category** M

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				COS	R
Supervision						
1	(IN)	OUT		PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A	Certified food protection manager, duties		
Employee Health						
3	(IN)	OUT		Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT		Proper use of reporting, restriction & exclusion		
5	(IN)	OUT		Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices						
6	(IN)	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT	N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands						
8	IN	OUT	(N/O)	Hands clean & properly washed		
9	IN	OUT	N/A (N/O)	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT		Adequate handwashing sinks supplied/accessible		
Approved Source						
11	(IN)	OUT		Food obtained from approved source		
12	IN	OUT	N/A (N/O)	Food received at proper temperature		
13	(IN)	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination						
15	(IN)	OUT	N/A N/O	Food separated and protected		
16	(IN)	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status				COS	R
Time/Temperature Control for Safety						
18	IN	OUT	N/A (N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A (N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A (N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A (N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A	Proper cold holding temperatures		
23	IN	OUT	N/A (N/O)	Proper date marking & disposition		
24	IN	OUT	(N/A) N/O	Time as a public health control: procedures & records		
Consumer Advisory						
25	IN	OUT	(N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations						
26	(IN)	OUT	N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances						
27	IN	OUT	(N/A)	Food additives: approved & properly used		
28	(IN)	OUT		Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures						
29	IN	OUT	(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

			COS	R
Safe Food and Water				
30	(IN) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
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		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/19/22

Inspector (Signature)