Electronically Delivered

March 3, 2023

Licensee
Ecumen Seasons At Apple Valley
15359 Founders Lane
Apple Valley, MN 55124

RE: Project Number(s) SL30758015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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.

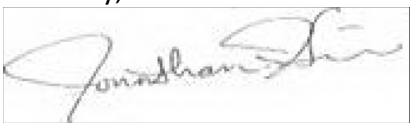
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30758	A. BUILDING: _____ B. WING _____	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT APPLE VALLEY	15359 FOUNDERS LANE APPLE VALLEY, MN 55124

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL30758105-0 On January 23, 2023, through January 24, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 49 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 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 January 23, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control, related to handwashing after topical medication application and instillation of eye drops, for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's service plan dated July 15, 2022, indicated R5 received medication administration, assistance with TED stocking application and removal, bathing assistance, oxygen saturation monitoring, and CPAP/BIPAP maintenance. On January 24, 2023, at 8:30 a.m., unlicensed	0 510		

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0 510	Continued From page 3 personnel (ULP)-E was observed to don gloves, instill Biontic eyes drops to R5, and remove soiled gloves without performing hand hygiene. ULP-E donned another pair of gloves, applied Diclofenac Sodium Cream to R5's knees, and removed the soiled gloves without performing hand hygiene.. ULP-E donned another pair of gloves, administered oral medications to R5, remove gloves, and performed hand hygiene. On January 24, 2023, at 8:45 a.m., during an interview, ULP-E stated she was trained and tested out in infection control procedures by a registered nurse. On January 24, 2023, at 9:15 a.m., clinical director (CD)-B stated ULP-E was trained in infection control procedures and should have sanitized or washed their hands in between tasks. The licensee's undated Hand Hygiene policy indicated, "handwashing shall be performed between client cares and whenever direct physical contact with a client take place. Use of gloves does not replace handwashing. Hands should be washed or decontaminated before and after direct contact with a client". No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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0 680	Continued From page 4 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to effect all residents, employees, and visitors to 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).	0 680		

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0 680	Continued From page 5 The findings include: On January 23, 2023, at approximately 11:30 a.m., executive director (ED)-A provided a binder and indicated the contents were the licensee's EP plan. The licensee's EP plan lacked: -annual review of policies and procedures; -quarterly missing resident plan review; -policy and procedures on volunteers; -emergency prep training and testing as required On January 23, 2023, at approximately 1:00 p.m., ED-A stated the licensee's emergency preparedness plan lacked the above listed required content. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but	0 780		

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0 780	Continued From page 6 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms in resident apartment units 213, 322, and 411, and working smoke alarms in resident apartment units 128 and 134. This has the potential to directly affect 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: On January 24, 2023, approximately from 11:00 a.m. to 4:00 p.m., survey staff toured the facility with the environmental services director (ESD)-F. During the tour, survey staff observed and the ESD-F tested and verified the following: 1. Inside the memory care studio unit 128, the	0 780		

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0 780	Continued From page 7 smoke alarm failed to sound when tested by the ESD-F. The ESD-F investigated the smoke alarm and stated it was unplugged and reconnected the alarm immediately. 2. Inside apartment unit 134, the required smoke alarm located outside the sleeping room of the one-bedroom resident apartment 134 failed to sound. The ESD-F confirmed the finding with his staff that the alarm outside the bedroom had not been replaced when the smoke alarm inside the sleeping room was last replaced. 3. Inside the one-bedroom apartment units 213, 322, and 411, the smoke alarms were not interconnected so the actuation of one alarm activates all alarms inside the apartment unit to sound. The findings were evident as the ESD-F tested the smoke alarms in each apartment unit and each smoke alarm sounded local and failed to sound the other smoke alarm in the apartment unit for proper notification. On January 24, 2023, at approximately 5:00 p.m., during the exit interview, the ESD-F and the executive (ED)-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the	0 800		

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0 800	Continued From page 8 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 24, 2023, approximately from 11:00 a.m. to 4:00 p.m., survey staff toured the facility with the environmental services director (ESD)-F. During the tour, survey staff observed and the ESD-F verified the following: 1. The corridor fire-rated doors for the 2nd-floor trash rooms failed to self-close and positively latch to protect and maintain the smoke-tight integrity of the 2nd-floor building corridor. 2. The 3rd-floor fire-rated stairway door next to the apartment unit 331 failed to positively latch when closed to protect and maintain the integrity of the vertical stairway enclosure in the means of egress. 3. The hot water dispensers, the stoves/ovens,	0 800		

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0 800	Continued From page 9 and the food warmers located in the common areas were accessible to memory care residents and posed safety concerns to residents. On January 24, 2023, at approximately 5:00 p.m., during the exit interview, the ESD-F and the executive (ED)-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the	0 810		

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0 810	Continued From page 10 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, record review, and interview, the licensee failed to provide the correct frequency of employee evacuation drills, and the minimum required training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, 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: On January 24, 2023, at approximately 4:00 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the environmental services director (ESD)-F. At approximately 4:30 p.m., document review and interview with the ESD-F and the executive director (ED)-A indicated the following	0 810		

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0 810	Continued From page 11 findings: 1. The facility training policy dated, March 31, 2022, incorrectly showed the employee training on fire safety and evacuation plan upon hire and annually. No record was available or provided for review. The minimum required employee training is upon hire and twice a year for fire safety and evacuation. 2. The licensee lacked a record to show that required annual resident training was available that can self-assist in their own evacuation on proper actions to take in the event of a fire including movement, evacuation, or relocation. No record was available or provided for review. 3. The drill records showed an insufficient number of employee fire safety and evacuation drills performed to date. Fire drill records received for review were dated January 7, 2023 (3 p.m.), November 23, 2022 (11:15 a.m), November 30, 2022 (6 a.m.), July 28, 2022 (2:15 p.m., April 4, 2022 (6 a.m.), and March 31, 2022 (10:15 a.m.). Survey staff explained to the ESD-F and the ED-A that the minimum required frequency of two evacuation drills for employees is twice per year per shift with at least one evacuation every other month. In addition, the drill records lacked evacuation drill information. On January 24, 2023, at approximately 5:00 p.m., during the exit interview, the ESD-F and the executive director (ED)-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (21) days	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 12	01060		
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 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 and the Office of Ombudsman for Mental Health and Developmental Disabilities; (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	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30758	A. BUILDING: _____ B. WING _____	01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT APPLE VALLEY	15359 FOUNDERS LANE APPLE VALLEY, MN 55124

(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
01060	Continued From page 13 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.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R2) who had an emergency relocation. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted on December 28, 2020. R2's Progress Notes dated October 28, 2022, at 6:54 p.m., indicated R2 was transported and admitted to the hospital. R2's Progress Notes dated November 1, 2022, at 6:09 p.m., indicated R2 returned from the hospital at 5:40 p.m., that day. R2's record lacked documentation R2 or R2's designated representative was provided an emergency relocation notice with the required content.	01060		

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01060	Continued From page 14 On January 24, 2023, at 2:00 p.m. clinical director (CD)-B indicated although the licensee had recently developed a procedure for emergency relocations, the licensee failed to provide the notice to any resident who required an emergency relocation. The licensee's Standard Operating Procedure (SOP): AL Resident Emergency Relocation SOP, dated March 2, 2022, indicated the required written notice with the required content for an emergency relocation would be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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ECUMEN SEASONS AT APPLE VALLEY	15359 FOUNDERS LANE APPLE VALLEY, MN 55124

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01790	Continued From page 15 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790		

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01790	Continued From page 16 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) who provided medications to residents for unplanned time away from home when the licensed nurse was not available for one of one employee (ULP-C) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on March 28, 2022. ULP-C's record lacked documentation of training and competency for unplanned time away related to medication administration when the RN is not available. On January 24, 2023, at approximately 2:00 p.m., executive director (ED)-A indicated ULP-C's record lacked documentation of training and competency for unplanned times away. ED-A stated ULP's contact the RN for direction when residents had unplanned time away. ED-A stated documentation of competency for residents unplanned time away would not be in any employee records.	01790		

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01790	Continued From page 17 The licensee's MED-4.0 Delegation of Medications to be Given to Clients by Unlicensed Staff for Clients Time Away from Home policy dated August 01, 2021, indicated the required training and competency for ULPs related to unplanned time away would be provided and included in the employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on the document review and interview, the licensee failed to develop a safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted	02040		

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02040	Continued From page 18 living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On January 24, 2023, at approximately 4:30 p.m., a documentation review and interview were performed with the environmental services director (ESD)-F and the executive (ED)-A on the hazard vulnerability assessment and mitigation plan for the memory care physical environment of the property. During the interview, the ED-A stated that they had not developed the hazard vulnerability assessment and mitigation plan on and around the property to protect the memory care residents from harm. This finding was evident as there was no plan documentation was provided for review. On January 24, 2023, at approximately 5:00 p.m., during the exit interview, survey staff discussed the findings and explained to the executive director (ED)-A that all potential safety risks or vulnerabilities including access to chemicals, sharp objects, potential elopement risks, hot surfaces in common areas, unsecured electric control panels inside each unit that control the furnaces, appliances, exterior ponds, and similar vulnerabilities on and around the property must be identified, assessed and mitigated or addressed, and be documented in the plan to	02040		

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02040	Continued From page 19 protect the memory care residents from harm. The ED-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02090 SS=F	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide responsible housing for residents in the memory care unit. This had the potential to effect all residents, employees, and visitors to 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: On January 24, 2023, at approximately 8:10 a.m., surveyors entered secured memory care unit and	02090		

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02090	Continued From page 20 observed a memory care unit key fob (used to exit memory care unit) located on top of a medication cart in the common hallway by the dining area. Multiple residents were seated in the dinng area awaiting breakfast, and additional residents were self-ambulating to the dining area from their respective rooms by the key fob on the medication cart. On January 24, 2023, at approximately 8:15 a.m., staff member entered secured memory care unit, approached medication cart, pushed the key fob back about one foot, and proceeded to locate other scheduled staff in resident rooms while leaving key fob unsecured. On January 24, 2023, at approximately 8:20 a.m., unlicensed personnel (ULP)-C approached the medication cart and began to prepare medication administration for a resident. As ULP-C was setting up the medications, noticed the key fob, and proceeded to secure key fob by placing lanyard around their neck. On January 24, 2023, at approximately 1:00 p.m., executive director (ED)-A and clinical director (CD)-B indicated all key fobs should be secured in the memory care unit. ED-A and CD-B indicated an unsecured key fob could result in elopement of memory care unit residents. ED-A indicated licensee's expectations were all key fobs would be secured. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02090		

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02110	Continued From page 21	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

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02110	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to five of five residents (R1, R2, R3, R4, and 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) 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: R1 was admitted on March 17, 2022. R1's record lacked documentation they or their designated representatives received the required policies and procedures (P/P) to be provided. R2 was admitted on December 28, 2020. R2's record lacked documentation they or their designated representatives received the required P/P to be provided. R3 was admitted on August 19, 2019. R3's record lacked documentation they or their designated representatives received the required P/P to be provided. R4 was admitted on June 9, 2022. R4's record lacked documentation they or their	02110		

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02110	Continued From page 23 designated representatives received the required P/P to be provided. R5 was admitted on August 30, 2022. R5's record lacked documentation they or their designated representatives received the required P/P to be provided. On January 24, 2023, at 1:00 p.m., executive director (ED)-A indicated the licensee was aware the identified policies and procedures were required to be provided to the residents at the time of move in. ED-A stated although the licensee had developed the required P/P, the licensee failed to provide the P/P to any resident who resided in the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *01/23/23*
Time: 08:28:32
Report: 1018231014

Food and Beverage Establishment Inspection Report

Location:
Ecumen Seasons At Apple Valley
15359 Founders Lane
Apple Valley, MN55124
Dakota County, 19

Establishment Info:
ID #: 0038945
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9526985300
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

ESTABLISHMENT DOES NOT HAVE A MAXIMUM TEMPERATURE REGISTERING THERMOMETER FOR THEIR DISHWASHER. COMPLY WITH RULE.

Comply By: 02/24/23

Surface and Equipment Sanitizers

SMARTPOWER: = 272PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

SMARTPOWER: = 272PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

SMARTPOWER: = 272PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

SMARTPOWER: = 272PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Hot Water: = at 168 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding/ LETTUCE
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ TOMATO
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ PUDDING
Temperature: 37 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ EGG
Temperature: 39 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ BUTTER
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ SOUP
Temperature: 37 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ HAM
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHICKEN
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Hot Holding/ SAUSAGE
Temperature: 187 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

Process/Item: Hot Holding/ SOUP
Temperature: 180 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

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

INSPECTION CONDUCTED WITH RHONDA MAKELA (MDH) PRESENT.

DISCUSSED EMPLOYEE ILLNESS AND ILLNESS POLICY.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1018231014 of 01/23/23.

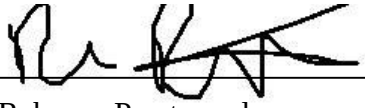
Certified Food Protection Manager: GAOZUAPA LY

Certification Number: 82796 Expires: 03/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

GAOZUAPA LY
KITCHEN MANAGER

Signed: 

Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us