Electronically Delivered

March 24, 2025

Licensee
New Challenges Inc. - Afton
6880 St. Croix Trail South
Hastings, MN 55033

RE: Project Number(s) SL28126016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 12, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28126	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CHALLENGES INC - AFTON	6880 ST. CROIX TRAIL SOUTH HASTINGS, MN 55033

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0 000	Initial Comments 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: SL28126016-0 On February 10, 2025, through February 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were nine residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 10, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been	0 730		

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0 730	Continued From page 4 provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for two of two residents (R2, R3) who utilized consumer bed rails. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on February 22, 2021. R2's [licensee] Uniform Assessment Tool sample form dated November 20, 2024, updated on January 28, 2025, by clinical nurse supervisor	0 730		

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0 730	Continued From page 5 (CNS)-C indicated R2 required side rail/bed rail for bed mobility. R2's record lacked evidence a risk and benefits were discussed with the resident or the resident's designated representative. R3 R3 was admitted to the licensee on November 14, 2024. R3's [licensee] Uniform Assessment Tool sample form dated November 27, 2024, completed by CNS-C indicated R3 required grab bars (term often used interchangeably with side rail or bed rail) for bed mobility. R3's record lacked evidence a risk and benefits were discussed with the resident or the resident's designated representative. On February 10, 2025, at 12:50 p.m., CNS-C stated although the licensee reviews the risk and benefits with every resident who used side rails, bed rails, or grab bars, when they are installed, the licensee did not document the discussion. CNS-C stated documentation of the discussion of the risks and benefits would need to be added to the licensee's resident assessment template. The Minnesota Department of Health's Assisted Living: Resources and Frequently Asked Questions (FAQs) website accessed February 12, 2025, at 9:58 a.m., indicated the risk vs benefits were required to be documented when completed with the resident or the responsible party. The licensee's 6.28 Side rails policy dated August 1, 2021, indicated the risk vs benefits would be provided to the resident or the responsible party	0 730		

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0 730	Continued From page 6 and documented in the resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: During facility tour on February 11, 2025, from 10:30 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-D and maintenance (M)-G, it was observed that the drywall was removed from the ceiling in the first-floor mechanical room.	0 775		

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0 775	Continued From page 7 Ceiling drywall must be put back to maintain the fire separation to the room above in accordance with MN State fire code. During a facility tour on February 11, 2025, at 11:30 a.m., LALD-D and M-G, verified the above listed observations while accompanying on the tour. M-G stated drywall was in place when facility was purchased but removed for maintenance and not noticed before now. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775		
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) staff 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) Staff 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	0 810		

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0 810	Continued From page 8 training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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 develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on February 11, 2025, from 10:45 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-D and maintenance (M)-G, surveyor observed the posted evacuation plans lacked identification of resident rooms. The fire safety and evacuation plan were not located in a central location for all staff, resident and visitor accessibility.	0 810		

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0 810	Continued From page 9 Exit plan diagrams must be correctly labeled and accessible to staff, residents and visitors to reduce confusion and potential obstructions for egress in a fire or similar emergency. A copy of the facility floor plan should also be in the emergency preparedness binder to aid first responders in search and rescue operations. On February 11, 2025, LALD-D provided documents on the fire safety and evacuation plan (FSEP), fire safety training and evacuation drills, for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated 08/01/2021, failed to include the following: Staff Actions: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. Resident Actions: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. Unique and unusual resident needs:	0 810		

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0 810	Continued From page 10 The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On February 11, 2025, at 12:30 p.m., LALD-D stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. Training: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, LALD-D stated they were using evacuation drills as training. No other training documentation was provided. The licensee failed to provide evacuation training to residents at least once per year. LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On February 11, 2025, at 12:30 p.m., LALD-D stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. Drills:	0 810		

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0 810	Continued From page 11 The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drills", undated, indicated evacuation drills were conducted only during the AM shift on February 3, 2025, August 30, 2024, July 15, 2024, and May 10, 2024. No other documentation was provided. On February 11, 2025, at 12:30 p.m., LALD-D stated there were no additional documented drills for the facility and would implement a program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01060		

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01060	Continued From page 12 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.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, 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	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28126	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CHALLENGES INC - AFTON	6880 ST. CROIX TRAIL SOUTH HASTINGS, MN 55033

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01060	Continued From page 13 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to licensee on February 22, 2021. R2's Uniform Assessment Tool sample form dated November 20, 2024, read on page 18 of 19, "[R2] was taken to Regina Hospital 1/25/25 for lethargy and impaired speech. He was admitted for UTI [urinary tract infection] and received IV [intravenous] abx [antibiotics], discharged back to [licensee] yesterday afternoon [January 27, 2025]." On February 12, 2025, at 9:30 a.m., clinical nurse supervisor (CNS)-C stated licensee did notify R2's guardian when R2 was taken to the hospital, but licensee did not provide a written notice with the required content. CNS-C stated licensee did email R2's guardian, but no written notice was provided, and licensee did not have a template for an emergency relocation notification with the required content. The licensee's 1.23 Emergency Relocation policy dated August 1, 2022, indicated the required content for a written emergency relocation notification and licensee would provide the written notice to the resident, legal representative, and designated representative as soon as practicable. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01290	Continued From page 14	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies (BGS) were associated with the licensee's current assisted living facility's health facility identification number (HFID) 28126 for two of two unlicensed personnel ((ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01290		

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01290	Continued From page 15 ULP-A and ULP-B were hired October 16, 2024, and November 14, 2024, respectively. ULP-A's BGS dated October 14, 2024, indicated ULP-A was affiliated with HFID 25523. ULP-B's BGS dated November 13, 2024, indicated ULP-B was affiliated with HFID 25523. The Department of Human Service's NETStudy2 screenshot dated February 11, 2025, at 11:44 a.m., indicated licensee's HFID 28126 roster included four people who were administration and lacked evidence any ULPs were associated with licensee's HFID. On February 11, 2025, at 12:20 p.m., licensed assisted living director (LALD)-D stated licensee had affiliated all employees with HFID 25523 which was associated with the licensee's previously held comprehensive home care license. LALD-D stated licensee would need to affiliate all employes with the current assisted living HFID, but each employee did have a cleared BGS. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated each employee would have a cleared BGS, but the policy failed to indicate each employee BGS would be affiliated with the licensee's specific HFID. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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01640	Continued From page 16	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and resident or resident's representative to document agreement of services to be provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01640		

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01640	Continued From page 17 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on February 22, 2021. On February 10, 2025, at 12:00 p.m., the surveyor requested R2's current record including R2's current authenticated service plan. R2's [licensee] Service Plan form signed February 10, 2025, was identified by licensed assisted living director (LALD)-D as R2's current service plan. On February 11, 2025, at 9:30 a.m., LALD-D stated licensee had authenticated R2's service plan after surveyor requested R2's service plan. LALD-D stated licensee authenticated all service plans for each resident but was unable to locate R2's current authenticated service plan. The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated the service plan and any revisions would include authentication by the licensee and the resident or legal representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 18 (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health	01730		

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01730	Continued From page 19 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management record with the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on February 22, 2021. R2's [licensee] Service Plan form signed February 10, 2025, was identified by licensed assisted living director (LALD)-D as R2's current service plan and indicated R2 required medication administration. R2's [licensee] Uniform Assessment Tool sample form dated November 20, 2024, updated on January 28, 2025, by clinical nurse supervisor (CNS)-C indicated R2 received medication management. R3 R3 was admitted to the licensee on November	01730		

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01730	Continued From page 20 14, 2024. R3's [licensee] Service Plan form signed December 4, 2024, was identified by LALD-D as R3's current service plan and indicated R3 required medication administration. R3's [licensee] Uniform Assessment Tool sample form dated November 27, 2024, completed by CNS-C indicated R3 received medication management. R2 and R3's medical records lacked individualized medication management programs (IMMP) including identification of the type of medication storage and the person responsible for managing refills for each resident. On February 11, 2025, at 9:55 a.m., CNS-C stated licensee had not included the type of storage or person responsible for the management of refills on any resident medication management program. CNS-C stated that although the licensee's assessment did not address those two areas as required, all medications are stored in a secured medication room and the CNS was responsible for managing refills for all residents. The licensee's 7.03 Medications Management Individualized Plan dated August 1, 2021, indicated all residents who received medication management services would have an IMMP which included the type of storage and person responsible for medication refills. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management record to include all required content for one of two residents (R3).	01940		

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01940	Continued From page 22 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: R3 was admitted to the licensee on November 14, 2024. R3's [licensee] Service Plan form signed December 4, 2024, was identified by licensed assisted living director (LALD)-D as R3's current service plan and indicated R3 required treatment services. R3's [licensee] Uniform Assessment Tool sample form dated November 27, 2024, completed by clinical nurse supervisor (CNS)-C indicated R3 received treatment services for lymphedema wraps, foot care, and continuous positive airway pressure (CPAP) with oxygen. R3's [licensee] Medical Visit Form dated January 16, 2025, included R3's provider order which read, "start wearing carpal tunnel braces on both wrists, especially at bedtime," and was initialed on the top right corner of the document by CNS-C as reviewed. R3's untitled document dated February 1, 202 (sic), was identified by CNS-C as R3's current monthly medication administration record (MAR), and where all treatments would be documented	01940		

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01940	Continued From page 23 when completed, lacked any reference R3's lymphedema wraps, foot care, or carpel tunnel braces had been initiated, monitored, administered, or documented. On February 12, 2025, at 9:30 a.m., CNS-C stated licensee did not implement R3's wrist braces and did not add the other treatments to R3's MAR. CNS-C stated all of R3's treatments should have been included on R3's MAR and a complete individualized treatment management plan (ITMP) should have been developed for each treatment. CNS-C stated licensee was not sure why R3's wrist brace order was not fully processed and complete ITMP was not developed and implemented. The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2021, indicated all required content for the licensee's ITMP and an IMTP would be developed and implemented for all prescribed treatments or therapy. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as	01960		

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01960	Continued From page 24 ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of administration or the reason why a treatment was not administered for one of two residents (R3) who had a treatment. 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: R3 was admitted to the licensee on November 14, 2024. R3's [licensee] Service Plan form signed December 4, 2024, was identified by licensed assisted living director (LALD)-D as R3's current service plan and indicated R3 required treatment services. R3's [licensee] Uniform Assessment Tool sample form dated November 27, 2024, completed by clinical nurse supervisor (CNS)-C indicated R3 received treatment services for lymphedema wraps, foot care, and continuous positive airway pressure (CPAP) with oxygen.	01960		

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01960	Continued From page 25 R3's [licensee] Medical Visit Form dated January 16, 2025, included R3's provider order which read, "start wearing carpal tunnel braces on both wrists, especially at bedtime," and was initialed on the top right corner of the document by CNS-C as reviewed. R3's untitled document dated February 1, 202 (sic), was identified by CNS-C as R3's current monthly medication administration record (MAR), and where all treatments would be documented when completed, lacked any reference R3's lymphedema wraps, foot care, or carpel tunnel braces had been initiated, monitored, administered, or documented. On February 12, 2025, at 9:30 a.m., CNS-C stated all of R3's treatment should have been included on R3's MAR. CNS-C stated licensee had not included all R3s treatments on R3's MAR and no documentation of administration or refusal of R3's lymphedema wraps, foot care, or wrist braces was included. CNS-C stated licensee would need to add the treatments to R3's MAR for staff to document administration or refusals of the treatments. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated documentation for all treatments ordered for each resident would be completed when each treatment was administered and if a treatment was refused or held. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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DEPARTMENT OF HEALTH

Type: Full
Date: *02/10/25*
Time: 16:45:09
Report: 1036251028

Food and Beverage Establishment Inspection Report

Location:

New Challenges Inc - Afton
6880 St. Croix Trail South
Hastings, MN55033
Washington County, 82

Establishment Info:

ID #: 0039313
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514540161
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO THIN PROBE THERMOMETER ON SITE. PROVIDE AND MAINTAIN.

Comply By: 03/03/25

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.

NO DEVICE ON SITE AS INDICTED ABOVE FOR MEASURING UST OF DISH MACHINE. MDH LEFT A COUPLE THERMOLABEL STICKERS DURING INSPECTION UNTIL MORE CAN BE OBTAINED.

Comply By: 03/03/25

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

ESTABLISHMENT HAD LEFTOVER FOOD IN THE FRIDGE THAT WAS COOKED, COOLED, AND THEY REHEAT. DISCONTINUE THIS PRACTICE AS THE SUBZERO 736TC UNIT IS NOT A COMMERCIAL GRADE UNIT.

Comply By: 02/13/25

Type: Full
Date: *02/10/25*
Time: 16:45:09
Report: 1036251028
New Challenges Inc - Afton

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 36 Degrees Fahrenheit - Location: SUB ZERO FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: SUB ZERO FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -2 Degrees Fahrenheit - Location: ROPER FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -10 Degrees Fahrenheit - Location: MAYTAG FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS BRANDON MUELLER. INSPECTION CONDUCTED IN PRESENCE OF DEB KREY, THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

ADDITIONAL TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- NO BHC WITH RTE FOODS.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING TCS FOODS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

Type: Full
Date: *02/10/25*
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Food and Beverage Establishment Inspection Report

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036251028 of 02/10/25.

Certified Food Protection Manager: REBEKAH G. SCHOENFELD

Certification Number: 123304 Expires: 05/14/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
DEB KREY
PERSON IN CHARGE

Signed: _____
Jeff Johanson