DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 30, 2022

Licensee
The Maples
2823 7th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL23690015

Dear Licensee:

On December 14, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 27, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

November 14, 2022

Administrator
The Maples
2823 7th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL23690015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 27, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23690	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAPLES	2823 7TH AVENUE NORTH ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project #SL23690015 On October 25, 2022, through October 27, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents, all of whom received services under the provider's Assisted Living license. On October 26, 2022, the immediacy of correction order 2310 has been removed, however non-compliance remains at a scope and level of G.	0 000		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose	0 250		

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0 250	Continued From page 1 a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services;	0 250		

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0 250	Continued From page 2 (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 25, 2022, at 10:15 a.m., director of nursing (DON)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services.	0 250		

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0 250	Continued From page 3 The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or	0 250		

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0 250	Continued From page 4 misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in	0 250		

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0 250	Continued From page 5 writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorized agent (AA)-I on June 15, 2022. The licensee had an Assisted Living license issued on August 1, 2022, with an expiration date of February 28, 2023. The licensee failed to ensure the following policies and procedures were implemented: (1) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (2) handling complaints regarding staff or services provided by staff; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (4) orientation to and implementation of the assisted living bill of rights; (5) infection control practices; (6) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (7) ensuring that nurses and licensed health professionals have current and valid licenses to practice;	0 250		

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0 250	Continued From page 6 (8) medication and treatment management; (9) delegation of tasks by registered nurses or licensed health professionals; (10) supervision of registered nurses and licensed health professionals; and (11) supervision of unlicensed personnel performing delegated tasks. On October 27, 2022, at 1:45 p.m., AA-I and DON-A confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0430, 0470, 0480, 0485, 0510, 0550, 0650, 0660, 0680, 0790, 0800, 0810, 0900, 1440, 1470, 1500, 1530, 1620, 1640, 1760, 1830, 1890, 1940, 1960, 2240, and 2310 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services	0 430		

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0 430	Continued From page 7 the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) to one of one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 admitted to licensee on April 10, 2018, and began services under the Assisted Living licensure on August 1, 2021. R2's record lacked documentation of acknowledgement or receipt of the UDALSA. On October 25, 2022, at 2:12 p.m., director of	0 430		

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0 430	Continued From page 8 nursing (DON)-A was not familiar with the UDALSA but remembered seeing it in the new admission paperwork. DON-A stated the current residents were not given the UDALSA effective August 1, 2021. The licensee's 1.04 Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy dated June 6, 2022, indicated the licensee will obtain written acknowledgement from the resident or resident representative that the licensee provided the UDALSA or document the reason why an acknowledgement was not obtained. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the	0 470		

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0 470	Continued From page 9 requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect the licensee's five residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The licensee was licensed for a bed capacity of eight (8) residents and had a current census of five (5) residents. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least	0 470		

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0 470	Continued From page 10 twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. During the entrance conference on October 25, 2022, at approximately 11:00 a.m., director of nursing (DON)-A stated staffing plans were discussed in nursing meetings but failed to document the staffing plan. The licensee's 4.06 Staffing & Scheduling policy dated June 6, 2022, indicated the licensee will assure qualified employees will be scheduled to meet operations requirements and the needs of the residents. The policy directed the clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The policy indicated the staffing levels would be based on resident's needs, acuity level, ability of staff to meet needs timely, and be based on staff experience, training and competency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 11 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the "Food and Beverage	0 480		

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0 480	Continued From page 12 Establishment Inspection Reports," dated October 26, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure at least three nutritious meals were served daily, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and	0 485		

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0 485	Continued From page 13	0 485		

fresh vegetables. This had the potential to affect all residents.

This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

The licensee failed to ensure the following:
- meals with seasonal fresh fruit and vegetables;
- meal substitutions will be of similar nutritional value if a resident refuses a food that is served; and
- meals according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines.

The licensee's undated Maples Menu, posted on the kitchen refrigerator, lacked consistent meals including half plate fruits and vegetables, one quarter plate protein, and one quarter plate grains. Additionally, the licensee lacked written meal substitution of similar nutritional value if a resident refused food served.

On October 25, 2022, at 12:00 p.m., lunch served was a cheese and butter sandwich, potato salad, canned mandarin oranges, and a beverage. The surveyor did not observe any fresh vegetables served.

On October 26, 2022, at 12:00p.m., lunch served was ribs, fried potatoes, fresh oranges, and a beverage. The surveyor did not observe any fresh

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0 485	Continued From page 14 vegetables served. On October 27, 2022, at 1:23 p.m., authorized agent (AA)-I and director of nursing (DON)-A acknowledged the menu did not meet the USDA guidelines. AA-I stated, "residents do not like to eat vegetables, so we don't serve it." The licensee's 12.01 Food Service & Menu Planning policy dated June 6, 2022, indicated food would be served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. The policy indicated the licensee would provide at least three meals daily with snacks available seven days per week according to the recommended dietary allowances in the USDA guidelines, including seasonal fresh fruit and fresh vegetables. The policy indicated meal substitutions wouldbe of similar nutritional value if a resident refuses a food that is served. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
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. (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.	0 510		

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0 510	Continued From page 15 (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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 25, 2022, at 12:20 p.m., the surveyor observed unlicensed personnel (ULP)-B perform a blood glucose check (for diabetes) on R2 prior to lunch. Once completed, ULP-B cleaned up the supplies and put them on the medication cart without doffing (removing) gloves. ULP-B charted the blood sugar result in R2's record then used keys to remove insulin from locked medication fridge. Without doffing contaminated gloves and washing hands, ULP-B proceeded to inject insulin to R2. Once completed with insulin administration, ULP-B doffed gloves. The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance in Health Care Settings last reviewed January 30, 2020, directed health care workers to use an alcohol-based	0 510		

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0 510	Continued From page 16 hand rub or wash with soap and water immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient and immediately after glove removal. On October 25, 2022, at approximately 12:30 p.m., the surveyor asked ULP-B and licensed practical nurse (LPN)-C if hand washing should have been performed after checking blood sugar and before insulin administration, both stated "yes." The licensee's 7.32 Blood Sugar Testing-Single Equipment Use policy dated July 25, 2022, indicated staff to doff gloves, discard gloves, and wash hands prior to documenting the results in the record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.	0 550		

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0 550	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect staff, visitors, and all five residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 25, 2022, at 10:55 a.m., during a facility tour, the surveyor observed the licensee lacked a posting of the above required content in a conspicuous place. On October 27, 2022, at approximately 1:45 p.m., authorized agent (AA)-I and director of nursing (DON)-A acknowledged the content had not been posted as required and understood the importance of posting it. The licensee's 2.09 Complaint/Grievance policy dated June 2, 2022, did not indicate the licensee would post the grievance procedure in a conspicuous place.	0 550		

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0 550	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 550		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.	0 650		

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0 650	Continued From page 19 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (unlicensed personnel (ULP)-E, director of nursing (DON)-A). 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: DON-A was hired on January 22, 2018. DON-A's record lacked evidence of current professional licensure and documentation of annual performance reviews that identified areas of improvement needed and training needs. ULP-E was hired on August 20, 2020. ULP-E's record lacked documentation of annual performance reviews that identified areas of improvement needed and training needs. On October 27, 2021, at 10:39 a.m., director of nursing (DON)-A stated employee evaluations are not completed for any employee. DON-A was unaware of this requirement. The licensee's 4.05 Employee Records policy dated June 6, 2022, indicated each employee record will include evidence of current professional licensure, registration, or certificate, if required.	0 650		

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0 650	Continued From page 20 The licensee's 4.35 Employee Evaluation policy dated June 6, 2022, indicated all employees will be given an employee evaluation at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). In addition, the licensee failed to ensure history and	0 660		

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0 660	Continued From page 21 symptom screening was completed and documented for one of three unlicensed personnel (ULP)-G. 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-G started employment on April 18, 2022. ULP-G's employee record lacked evidence a history and symptom screening was completed by the licensee. On October 27, 2022, at 10:43 a.m., director of nursing (DON)-A verified the TB policy did not designate who will be responsible for the TB program. DON-A stated the licensee had never done a TB risk assessment and did not know what it was. Additionally, DON-A indicated ULP-G's record contained a TB symptom screen from a prior employment dated June 2021. The licensee's 8.16 Tuberculosis Screening policy dated June 6, 2022, indicated the licensee will identify an individual staff member responsible for the TB program. The policy also indicated the licensee will maintain a current community TB risk assessment and will be updated annually, using the data and form provided by the Minnesota Department of Health. Additionally, all new staff will be screened for active signs of TB using the Baseline TB	0 660		

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0 660	Continued From page 22 Screening Tool for all health care workers and will be kept in each employee medical file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 23 by: Based on interview and record review, the licensee failed to develop a written emergency disaster plan with all the required content. The licensee also failed to post the emergency disaster plan prominently. This had the potential to affect all five residents receiving services under the assisted living licensure. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: On October 27, 2022, at 10:25 a.m., the surveyor requested to view the licensee's emergency preparedness plan from director of nursing (DON)-A. The information was not posted in a prominent location, it was located within a large bookcase along with many other binders and other material. The licensee's Emergency Response Plan (Disaster Plan) last reviewed on January 2, 2017, included contact information for some internal emergency such as nursing staff, maintenance and licensee and external service contacts for food and water, portable restrooms and shelter. The provided EP plan lacked individualized emergency procedures to include the following: - establish and maintain a comprehensive EP, reviewed/updated annually;	0 680		

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0 680	Continued From page 24 - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - documented date of reviews and updates; - risk assessment with documentation; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - develop strategies for addressing community-based risks (evacuation plans, staffing/shortage, back-up plans); - missing resident plan; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - develop and implement EP policies/procedures and review/update annually; - develop/implement EP policies and procedures to address evacuation and shelter in place for staff and residents which must include: - alternate sources of energy to maintain temperature, safety and sanitary storage of provisions; - alternate sources of energy to fire detection, extinguishing, alarms systems; - sewage and waste disposal; - a tracking system used to document locations of	0 680		

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0 680	Continued From page 25 residents, staff, and relocation of staff; - develop policies and procedures to address safe evacuation from the facility including: - needs of evacuees; - staff responsibilities; - transportation; - evacuation location; - alternate communication means; - develop policy and procedures for shelter in place for residents, staff and volunteers who remain at the facility; - develop policy and procedures to address: - systems of medical documentation that preserve resident information; - protects confidentiality; - secures/maintains availability of records; - develop policy and procedures must address use of volunteers including process and role for integration; - develop policy and procedures which address development and arrangements with other facilities or providers to receive residents in the event continuity of services cannot be provided; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - communication plan must include all the following names/contact information: - staff; - entities providing services under agreement; - residents' physicians; - other facilities; - volunteers; - communication plan must include contact information for: - Federal, State, tribal, regional, and local EP staff; - State Licensing and Certification Agency;	0 680		

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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
0 680	Continued From page 26 - MN Office of Ombudsman for LTC; - other sources of assistance; - communication plan must include; - method for sharing information and medical documentation for residence; - means, in event of evacuation, to release resident information; - means of providing information about general condition and location of residents under [licensee's] care; - communication plan must include: - means to provide information about facility occupancy; - needs; - and ability to provide assistance; - authority having jurisdiction; - incident Command Center; - or designee; - communication plan must include A method for sharing information from emergency plan; - must develop and maintain EP training and testing program, review/update annually; - training program must include initial EP training to policies and procedures to all new and existing staff and volunteers; - provide EP training at least annually; - maintain documentation of EP training; - demonstrate staff knowledge of EP; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; - must implement emergency and standby power systems based on their EP; and - if part of a healthcare system consisting of separately certified healthcare facilities and elects to have a unified and integrated EP, they may choose to participate. On October 27, 2022, at approximately 1:45 p.m., authorized agent (AA)-I and DON-A confirmed the	0 680		

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	23690	A. BUILDING: _____ B. WING _____	10/27/2022

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0 680	Continued From page 27 licensee had not fully developed and implemented the licensee's emergency preparedness plan/program. The licensee's 9.01 Emergency Preparedness Plan-Appendix Z Compliance policy dated June 6, 2022, noted the licensee would include all required elements of appendix Z. The plan would be in writing and reviewed annually. The key elements of the plan would include risk assessment and planning, policies and procedures, a communication plan and staff training and exercises/drills. The policy did not indicate the emergency plan needed to be posted prominently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	0 790		

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0 790	Continued From page 28 Based on observation, record review, and interview, the licensee failed to maintain the portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 26, 2022, approximately from 9:30 a.m to 10:45 a.m., survey staff toured the home with the director of maintenance (DM)-F. During the tour of the home, survey staff observed and the DM-F confirmed the following: 1) No portable fire extinguisher was visible on the main floor. The finding was evident as the DM-F explained that the extinguisher was located under the kitchen sink cabinet. In addition, the licensed practical nurse-C clarified that the extinguisher was located inside the closet and not under the kitchen sink cabinet. Survey staff explained to the DM-F that the extinguishers must be mounted in a visible location or located inside a cabinet with proper signage to indicate their location. 2) No records or tags to show the required monthly quick checks. On October 26, 2022, at approximately 11:15 a.m., at the exit interview, the DM-F	0 790		

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0 790	Continued From page 29 acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: 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 occupied residents, visitors, 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, 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 are:	0 800		

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0 800	Continued From page 30 On October 26, 2022, approximately from 9:30 a.m -10:45 a.m., survey staff toured the home with the director of maintenance (DM)-F. During the tour of the home, survey staff observed and the DM-F confirmed the following: 1) The interior windows in resident bedrooms 2 and 3 on the main floor level had condensation. In addition, the windowsills were dirty with dust, moisture, and some mold growth on the surface from the moisture. 2) No privacy locks or provision for privacy were provided for resident bedrooms 1, 2, and 4. 3) The lock hardware on the front entrance storm door was not easily operable and needed to be repaired. 4) The lock hardware in lower-level resident bedroom #5 was not easily operable and needed to be repaired or replaced. 5) The lower-level bathroom was missing ceiling tiles. 6) The air return grilles in resident bedroom 2 and the lower-level floor living room was dirty and layered with thick dust. On October 26, 2022, at approximately 11:00 a.m., at the exit interview, the DM-F 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	0 810		

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0 810	Continued From page 31 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one 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 record review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the required training on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of occupied residents receiving care, staff, and	0 810		

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0 810	Continued From page 32 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 October 26, 2022, at approximately 10:45 a.m., survey staff received the home's fire safety and evacuation plan and related documentation. Document review and interview with the director of maintenance (DM)-F at approximately 11:00 a.m. indicated the following: FIRE SAFETY AND EVACUATION PLAN The fire safety and evacuation plan lacked complete fire protection procedures necessary for residents to address unique resident-specific situations during an evacuation from fire or similar emergency. Unique situations that must be considered during an evacuation could be residents who have mobility limitations, cognitive impairment, deaf or blind, or any residents needing assistance including movement and evacuation that must be addressed in the fire safety and evacuation plan. DRILLS No recent evacuation drill records were provided for review. Document review showed the last drill documented was February 27, 2017. The DM-F asked the licensed practical nurse (LPN)-C for additional drill records. The LPN-C explained that she had been performing fire drills but did not	0 810		

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0 810	Continued From page 33 document them. She also commented that she oversees fire drills for three houses and performs drills on the first Wednesday of each month for each house by rotation. Survey staff explained to the DM-F and the LPN-C that the minimum required number of evacuation drills must be twice per year per shift, with at least one evacuation drill every other month for this home and they will need to maintain records to show compliance with the requirement. TRAINING 1) No record of required employee training on the home's fire safety and evacuation plan. Survey staff explained to the DM-F that employee training on fire safety and evacuation training is required at minimum upon hire and twice a year, thereafter. 2) No record of required annual training of residents capable of assisting with proper actions to take in the event of a fire including movement, evacuation, and relocation. On October 26, 2022, at approximately 11:15 a.m., the DM-F acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.	0 900		

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0 900	Continued From page 34 (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for four of four residents (R1, R2, R3, R4).	0 900		

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0 900	Continued From page 35 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee began operations under their assisted living facility license on August 1, 2021. On October 25, 2022, the licensee provided a blank assisted living lease contract and indicated the contract is used by the licensee for all residents who received services by licensee. R1 R1 was admitted on November 16, 2009. R1's record included a Client Agreement dated November 16, 2009. R1's record lacked an assisted living contract with required content. R2 R2 was admitted on April 10, 2018. R2's record included a Client Agreement signed on April 10, 2018. R2's record lacked an assisted living contract with required content. R3 R3 was admitted on November 27, 2019. R3's record included a Client Agreement signed on November 27, 2019. R3's record lacked an assisted living contract with required content.	0 900		

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0 900	Continued From page 36 R4 R4 was admitted on July 6, 2017. R4's record included a Client Agreement signed on July 6, 2017. R4's record lacked an assisted living contract with required content. R1, R2, R3, and R4's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable In addition, R1, R2, R3, and R4's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. On October 27, 2022, at approximately 1:50 p.m., authorized agent (AA)-I and director of nursing (DON)-A acknowledged the licensee's assisted living contract was not included in R1, R2, R3 and R4's record. DON-A indicated the assisted living contract was given to all new residents but was unaware the current residents needed to be provided with this contract.	0 900		

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0 900	Continued From page 37 The licensee's 1.05 Signing an Assisted Living Contract policy dated June 6, 2022, indicated when a prospective resident decides to move into the licensee, an Assisted Living contract will be signed and received by the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440		

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01440	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of direct supervision of unlicensed personnel (ULP) for two of two employees (ULP-E, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E and ULP-G had a hire date of August 20, 2020, and April 18, 2022, respectively. ULP-E and ULP-G's employee records lacked documentation of direct supervision to verify the work was being performed competently, to identify problems and solutions to address issues relating to the ULPs' ability to provide the services. On October 26, between 8:25 a.m. and 8:45 a.m., ULP-E provided assisted living services including medication administration and blood glucose check to R2. On October 27, 2022, at 9:19 a.m., director of nursing (DON)-A stated the delegated tasks are done on site with either the team lead (ULP) or the licensed practical nurse (LPN). DON-A stated	01440		

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01440	Continued From page 39 they do not always sign off on the delegated tasks. The licensee's 6.17 Supervision of Staff-Delegated Services policy dated June 6, 2022, indicated it is the responsibility of the registered nurse staff to ensure the supervision is done within the time frames outlined above and specified on the client's service plan. Additionally, it indicated documentation of supervision activities will be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct	01470		

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01470	Continued From page 40 support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01470		

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	23690	A. BUILDING: _____ B. WING _____	10/27/2022

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01470	Continued From page 41 licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for two of three employees (unlicensed personnel (ULP)-G, director of nursing (DON)-A). 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-G ULP-G was hired on April 18, 2022. ULP-G's employee record lacked evidence to indicate the employee had received orientation to include the following topics: - an overview of Assisted Living laws 144G, - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person, - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints, and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. DON-A DON-A was hired on January 22, 2018. DON-A's employee record lacked evidence to indicate the employee had received orientation to	01470		

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01470	Continued From page 42 include the following topics: -overview of Assisted Living Laws 144G, and -Assisted Living bill of rights. On October 27, 2022, at 11:02 a.m., medical records (MR)-H stated during orientation training, all employees were not trained on complaint/grievances and principles of person-centered care. MR-H indicated employees are given a printout of the Assisted Living Statutes, but there was no acknowledgment in employee records. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated June 6, 2022, noted all employees must complete orientation to include the above content. Additionally, the policy indicated there must be evidence of completed orientation topics in employee records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the	01500		

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01500	Continued From page 43 exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology	01500		

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01500	Continued From page 44 that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-E, director of nursing (DON)-A). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired on August 20, 2020. On October 26, 2022, from 8:25 a.m. to 8:45 a.m., ULP-E provided assisted living services including medication administration and blood glucose check to R2. ULP-E's employee record lacked evidence of eight hours of annual training. DON-A DON-A was hired on January 23, 2018.	01500		

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01500	Continued From page 45 DON-A's employee record lacked evidence of eight hours of annual training. On October 27, 2022, at 10:39 a.m., DON-A indicated she was unaware of the annual training requirement for supervisors. On October 27, 2022, at 11:02 a.m., medical records (MR)-H stated there were no record of DON-A receiving annual training. The licensee's Annual Training policy dated February 24, 2021, indicated "direct-care staff will complete 8 hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not	01530		

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01530	Continued From page 46 provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of two employees (unlicensed personnel (ULP)-G, director of nursing (DON)-A) received the required amount of dementia care training, in the required time frame. 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: ULP-G ULP-G was hired on April 18, 2022, to provide direct care services to residents at the assisted living. ULP-G's employee record contained	01530		

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01530	Continued From page 47 documentation that on April 18 and 20, 2022, ULP-G had received four hours of dementia related training. ULP-G's record lacked the required eight hours of initial training. ULP-G completed 160 hours of employment on May 20, 2022. DON-A DON-A began employment on January 22, 2018, under the comprehensive home care license and provided direct care and supervision of staff under the assisted living license as of August 1, 2021. DON-A's employee record lacked documentation of eight hours of dementia training being completed. On October 27, 2022, at 9:19 a.m., medical records (MR)-H indicated all staff received approximately four hours of dementia training during new hire orientation. The licensee's 5.03 Dementia Training policy dated June 6, 2022, indicated direct care employees will complete eight hours of initial training within 160 hours of the employment start date. Additionally, it indicated all staff will complete two hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 48 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for one of one resident (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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01620		

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01620	Continued From page 49 or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee on April 10, 2018. On October 26, 2022, at 8:25 a.m., ULP-E administered medications to R2. R2's Client Service Plan dated February 25, 2022, indicated R2 received services to include medication administration, wound care, bathing assistance, dressing, grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, and mobility assistance as needed. R2's Monitoring and Reassessment 90 Day Client Assessment dated October 1, 2022, lacked areas required on the uniform assessment tool including: - the resident's personal lifestyle preferences, -activities of daily living, - physical health status, -emotional and mental health conditions -cognition, -communication and sensory capabilities, -pain, -skin conditions, -nutritional and hydration status and preferences, -list of treatments, including type, frequency, and level of assistance needed, -risk indicators, -who has decision-making authority for the resident, and -the need for follow-up referrals for additional medical or cognitive care by health professionals	01620		

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01620	Continued From page 50 On October 27, 2022, at 12:43 p.m., director of nursing (DON)-A acknowledged the licensee's nursing assessments did not include all information from the uniform assessment tool and stated this nursing assessment was used for all residents. The licensee's 6.03 Uniform Assessment Tool policy dated June 6, 2022, indicated a registered nurse would utilize a uniform assessment tool that included all information. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated June 6, 2022, indicated the nursing assessments must include all the elements of the uniform assessment tool as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting 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	01640		

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01640	Continued From page 51 Long-Term Care. (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 a current written service plan was revised to reflect the current services provided for one of one resident (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 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 April 10, 2018. R2's diagnoses included but were not limited to open wound to abdominal wall, hypothyroidism (decreased thyroid hormone), diabetes mellitus-type 2, edema (swelling), and reflux. On October 26, 2022, at 3:35 p.m., the surveyor observed R2 without compression socks (long,	01640		

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01640	Continued From page 52 tight-fitting stockings that place pressure on the legs to reduce swelling). R2 stated they wore the compression socks but had not worn them for the last two days because their toenails were long and would snag the socks. The surveyor observed a pair of compression socks draped over the walker in R2's room. R2's Client Service Plan dated February 25, 2022, did not indicate R2 received compression sock treatment. R2's Treatment/Therapy Management Plan dated April 10, 2022, lacked indication R2 had the treatment of compression socks. R2's current prescriber's orders signed October 10, 2022, lacked orders to apply compression socks but had prescribed orders for compression socks dated February 22, 2021. R2's medication administration record (MAR) dated October 2022, indicated R2 had compression stockings applied and removed daily. On October 27, 2022, at 1:55 p.m., director of nursing (DON)-A and licensed practical nurse (LPN)-D acknowledged R2's service plan lacked inclusion of the compression sock treatment for R2. DON-A indicated the service plan would be updated to include compression sock treatment. The licensee's 6.10 Service Plan Modifications policy dated June 6, 2022, indicated when a resident receives assisted living services and a change to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative.	01640		

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01640	Continued From page 53 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the documentation included the signature and title of the person who administered the medication for two of four residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01760		

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01760	Continued From page 54	01760		

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

The findings include:

R2
R2 admitted for services on April 10, 2018.

R2's diagnoses included but were not limited to, open wound to abdominal wall, hypothyroidism (decreased thyroid hormone), diabetes mellitus-type 2, edema (swelling), and reflux.

R2's Service Plan dated February 25, 2022, indicated R2 received medication administration three times daily and as needed (PRN). R2 received insulin administration four times daily.

R2's medication administration record (MAR) dated October 2022, indicated:
- on October 4, 2022, at 2:00 p.m., and October 6, 2022, at 8:00 p.m., R2 did not receive lubricant eye drops 0.4-0.3 in each eye
- on October 20, 2022, R2 did not receive Preservision Areds 2 soft gels and two tablets of Senna Plus 8.6-50 milligrams (mg) by mouth at 8:00 p.m. Additionally, R2 did not receive Diclofenac Sodium gel to right knee at 8:00 p.m.

R4
R4 was admitted for services on July 6, 2017.

R4's diagnoses included but not limited to, asthma, borderline personality disorder, pelvic pain, schizoaffective disorder, type 2 diabetes.

R4's Client Service Plan signed on February 8, 2022, indicated R4 received medication administration two times daily and PRN.

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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
01760	Continued From page 55 R4's MAR dated October 2022, indicated: - on October 11 and 12, 2022, R4 did not receive two tablets of melatonin 3 mg by mouth at 8:00 p.m. R2 and R4's medication record lacked documentation why the medications were not given. On October 27, 2022, at 9:30 a.m., licensed practical nurse (LPN)-C was not sure why the medication administrations were not documented. The licensee's 7.22 Medications & Treatment Record-Documentation & Refusal policy dated July 25, 2022, indicated if medication was not given, documentation must include the reason why it was not completed and any follow up procedures that were provided. Additionally, the policy indicated documentation of medication administration will be completed by the person who performed the task immediately after medication administration is completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced	01830		

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01830	Continued From page 56 by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (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 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 admitted for services on April 10, 2018. R2's diagnoses included, but were not limited to, open wound to abdominal wall, hypothyroidism (decreased thyroid hormone), diabetes mellitus-type 2, edema (swelling), and reflux. R2's Client Service Plan dated February 25, 2022, indicated R2 received services to include medication administration, wound care, bathing assistance, dressing, grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, and mobility assistance as needed. R2's Client Data-Medical Visit, which was signed by an orthopedic physician on October 10, 2022, acknowledging the medications R2 was on but R2's record lacked annual signed physician orders by the primary care physician as required. On October 27, 2022, at 9:50 a.m., director of	01830		

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01830	Continued From page 57 nursing (DON)-A indicated R2's record lacked signed annual physician orders. DON-A indicated the primary physician would not sign their Emergency Form which includes a list of R2's medications. On October 27, 2022, at 11:15 a.m., DON-A provided surveyor signed orders during survey by the physician for R2. The licensee's 7.18 Medication & Treatment Orders-Renewal policy dated June 6, 2022, indicated the licensee will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required and placed in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medication dates for three of four residents (R1, R3, R4).	01890		

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01890	Continued From page 58 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 October 25, 2022, at 10:15 a.m., during entrance conference, director of nursing (DON)-A indicated the licensee provided medication administration to all residents. On October 26, 2022, at 8:25 a.m., unlicensed personnel (ULP)-E provided medication administration to R2 On October 27, 2022, at 8:37 a.m., licensed practical nurse (LPN)-C provided medication administration to R3. On October 27, 2022, at 9:05 a.m., the surveyor reviewed the medication cart with LPN-C. The surveyor noted expired medications for R1, R3, and R4. R1 R1's Client Service Plan signed November 30, 2021, indicated R1 received medication administration services. R1's loperamide 2 milligrams (mg) expired on December 16, 2021. R3 R3's Client Service Plan signed August 2, 2022, indicated R3 received medication administration	01890		

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01890	Continued From page 59 services. R3 had the following expired medications: -oxycodone/acetaminophen 5-325 mg (two tablets) was dispensed by the pharmacy on April 21, 2021. The bubble pack the medication was stored in did not have an expiration date listed. DON-A contacted pharmacy and pharmacist stated it is good for one year. The expiration date for this medication was April 21, 2022. -lorazepam 0.5mg (15 tablets) expired July 13, 2022, -lorazepam 0.5mg (9 tablets) expired on April 20, 2022, -albuterol Sulfate 1.25mg/3 milliliters (ml) (25 vials) expired January 2022, and -headache relief acetaminophen/aspirin/caffeine approximately one quarter bottle full expired March 2022. R4 R4's Client Service Plan signed February 8, 2022, indicated R4 received medication administration services. R4 had the following expired medications: -loperamide 2 mg capsules (full bottle) expired on January 26, 2022, and -guaifenesin 200mg (cough medicine) expired on October 18, 2021. On October 27, 2022, LPN-C and DON-A indicated there was no scheduled plan where nursing staff would check for expired medications. DON-A stated the medications that run low will get refilled. The licensee's 7.11 Medication Storage policy dated July 25, 2022, indicated medications will be stored consistent with manufacturer's	01890		

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01890	Continued From page 60 recommendations. The policy lacked instruction to staff for checking expiration dates. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01940		

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01940	Continued From page 61 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individual treatment management plan to include all required content for one of one resident (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 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's diagnoses included, but were not limited to, open wound to abdominal wall, hypothyroidism (decreased thyroid hormone), diabetes mellitus-type 2, edema (swelling), and reflux. On October 26, 2022, at 3:35 p.m., the surveyor observed R2 without compression socks (long, tight-fitting stockings that place pressure on the legs to reduce swelling). R2 stated they wore the compression socks but had not worn them for the last two days because their toenails were long and would snag the socks. R2's Client Service Plan dated February 25, 2022, did not indicate R2 received compression sock treatment. R2's Treatment/Therapy Management Plan dated	01940		

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01940	Continued From page 62 April 10, 2022, lacked indication R2 had the treatment of compression socks R2's current prescriber's orders signed October 10, 2022, lacked orders to apply compression socks but had prescribed orders for compression socks dated February 22, 2021, which is beyond one year. R2's medication administration record (MAR) dated October 2022, indicated R2 had compression stockings applied and removed daily. On October 27, 2022, at 1:55 p.m., director of nursing (DON)-A and licensed practical nurse (LPN)-D acknowledged R2's treatment management plan, current physician orders and service plan lacked inclusion of the compression sock treatment for R2. DON-A indicated the treatment management plan would be updated to include compression sock treatment. The licensee's 7.05 Treatment & Therapy Management Plan dated June 6, 2022, indicated the treatment or therapy management record must be current and updated when there are any changes. No further information was 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	01960		

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01960	Continued From page 63 record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment administration 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 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's diagnoses included, but were not limited to, open wound to abdominal wall, hypothyroidism (decreased thyroid hormone), diabetes mellitus-type 2, edema (swelling), and reflux. . R2's Client Service Plan dated February 25, 2022, indicated R2 received assistance with continuous positive airway pressure (CPAP) treatment therapy. R2's Treatment/Therapy Management Plan dated April 10, 2022, indicated R2 received CPAP	01960		

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01960	Continued From page 64 treatment therapy. R's prescriber's orders dated October 10, 2022, indicated R2 had the following signed orders for CPAP: -Home CPAP setting every night and when napping 8:00 p.m. -Fill CPAP reservoir with distilled water at bedtime 10:00 p.m. R2's medication administration record (MAR) dated October 2022, lacked documentation of service provided and why it wasn't provided on the following days: -October 5, 6, 13, 17, 18, and 20, for filling R2's CPAP reservoir with distilled water at bedtime; -October 3, 7-11, 13, 14, and 18-26, for washing CPAP chamber, mask cushions daily with soap and water; -October 15, for replacing the filter monthly; -Lack of documentation of weekly tube wash, headgear, and other parts with warm soapy water; and -Lack of documentation of weekly chamber wash with warm soapy water then soak in vinegar solution. On October 27, at 9:25 a.m., director of nursing (DON)-A and licensed practical nurse (LPN)-C acknowledged the MAR did not indicate dates for the weekly CPAP wash and acknowledged CPAP services were not documented on the above dates. The licensee's 7.22 Medication & Treatment Record-Documentation & Refusal policy dated June 6, 2022, indicated documentation of treatment or therapy administration will be completed by the person who performed the task immediately after the administration is completed.	01960		

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01960	Continued From page 65 Additionally, the policy indicated if the treatment or therapy were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01960		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing	02240		

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02240	Continued From page 66 address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights (BOR) for Assisted Living Residents was provided to one of one resident (R2). This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee transitioned from a comprehensive home care license to an assisted living license on August 1, 2021.	02240		

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02240	Continued From page 67 R2's Client Service Plan dated February 25, 2022, indicated R2 received services to include medication administration, wound care, bathing assistance, dressing, grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, and mobility assistance as needed. R2's record included an acknowledgement for a copy of the Home Care BOR form, signed on April 19, 2022. On October 27, 2022, at 1:45 p.m., authorized agent (AA)-I and director of nursing (DON)-A, indicated the residents did not receive the current Minnesota BOR for Assisted Living Residents. DON-A also indicated the current Minnesota BOR are given to all new admissions. They were unaware the current residents needed to be provided the current Minnesota BOR. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and	02310		

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02310	Continued From page 68	02310		

services according to acceptable health care standards, medical or nursing standards for one of two residents (R2) who utilized side rails.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:

On October 25, 2022, at approximately 11:26 a.m., during the initial tour with licensed practical nurse (LPN)-C, the surveyor observed a bilateral (two sides) side rails on R2's hospital bed. LPN-C stated R2 used side rails for bed positioning and to promote independence.

R2 was admitted on April 18, 2018.

R2's Client Service Plan dated February 25, 2022, indicated R2 received services including medication management, assistance with bathing, grooming, dressing, wound care, behavior management, and assistance with mobility as needed.

R2's Vulnerability Assessment/Abuse Prevention Plan dated April 10, 2022, indicated under "has side rails," it was checked "false."

On October 26, 2022, at approximately 9:25 a.m., LPN-C stated when it is marked "false," it indicated the resident did not have a siderail.

R2's most recent Monitoring and Reassessment

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THE MAPLES	2823 7TH AVENUE NORTH ANOKA, MN 55303

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02310	Continued From page 69 dated October 1, 2022, lacked an assessment for side rail use. R2's Tasks Assigned/Plan of Care dated July 7, 2022, indicated R2 was independent with mobility, however lacked any indication of side rail use. R2's record lacked any side rail assessment, measurements of side rails, and documentation of risk verses benefit discussion. On October 26, 2022, at approximately 8:53 a.m., LPN-C indicated they were unable to locate R2's side rail assessment and risk versus benefit acknowledgement. On October 26, 2022, at approximately 9:06 a.m., LPN-D indicated side rail assessment and risk versus benefit should be completed initially, annually and after change of condition. The licensee's 6.28 Side Rails policy dated June 6, 2022, indicated when side rails are in use, a registered nurse (RN) must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The Food and Drug Administration's (FDA) A Guide to Bed Safety, dated March 10, 2006, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23690	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAPLES	2823 7TH AVENUE NORTH ANOKA, MN 55303

(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
02310	Continued From page 70 them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed evaluation supervisor document review on October 26, 2022, however noncompliance remains at a scope and severity of G. TIME PERIOD FOR CORRECTION: Seven (7) Days	02310		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *10/26/22*
Time: 10:00:58
Report: 1029221355

Food and Beverage Establishment Inspection Report

Location:
The Maples
2823 7th Avenue North
Anoka, MN55303
Anoka County, 02

Establishment Info:
ID #: 0039167
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637128363
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS items in the refrigerator door measured 41°F and were discarded. Item in the interior of the refrigerator measured at 41°F. Instructed operator to reduce temperature in refrigerator to maintain all items at 41°F or below.

Comply By: 10/26/22

4-500 Equipment Maintenance and Operation
4-501.114C3 ***** Priority 1 *****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

Quaternary ammonium sanitizer compound used to sanitize food contact surfaces is lemon scented, and did not meet the needed minimum concentration to sanitize food contact surfaces. Instructed operator to use sanitizer that can be verified to sanitize.

Comply By: 10/26/22

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.

Small diameter probe thermometer not at establishment. Instructed operator to obtain a small diameter

probe thermometer.
Comply By: 11/04/22

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.
Temp stickers or thermometer not available to verify the temp reached in the dish washer. Instructed operator to obtain thermometer or temp stickers. Provided operator with small amount of temp stickers during the inspection.

Comply By: 10/26/22

4-300 Equipment Numbers and Capacities
4-302.14 ***** Priority 2 *****
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
Test strips not on site to test sanitizer. Instructed operator to obtain test strips to verify sanitizer is at the needed concentration.

Comply By: 10/26/22

3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
Damp wiping cloth not in use and on sink area. Instructed operator to hold damp wiping cloths in a sanitizer solution if they are not in use.

Comply By: 10/26/22

4-200 Equipment Design and Construction
4-201.11AMN
MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
Dish washing machine did not bear the certification to NSF/ANSI Standard 184 for residential dish washers. Instructed operator to sanitize by other means until they are able to obtain an NSF/ANSI Standard 184 dish washer for sanitizing kitchen items.
Comply By: 10/26/22

Surface and Equipment Sanitizers

Quaternary ammonium: = 0-50 ppm at Degrees Fahrenheit
Location: Sanitizer spray bottle
Violation Issued: Yes

Quaternary ammonium: = 0-50 ppm at Degrees Fahrenheit
Location: Santizer spray bottle
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Butter
Temperature: 47 Degrees Fahrenheit - Location: Refrigerator door
Violation Issued: Yes

Process/Item: Sliced cheese
Temperature: 48 Degrees Fahrenheit - Location: Refrigerator door
Violation Issued: Yes

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator interior
Violation Issued: No

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

This inspection was conducted in conjunction with an HRD survey at The Maples, located at 2823 7th Avenue North, Anoka, MN 55303. Establishment serves 5 residents aged 43-70 years old.

The inspection was conducted in the presence of Nicole Aldes, LPN - CFPM, and other staff. All issues were discussed with Nicole during and after the inspection. Employee illness reporting and exclusion procedures were also discussed. All issues were communicated to lead HRD surveyor Anna Bohnen, RN Nurse Evaluator, following the inspection.

Kitchen has pergo flooring, stone/granite countertops, tile backsplash extending around entire kitchen, and smooth painted walls and ceiling. Cabinetry is composite/wood material with laminate surfaces. Excluding minor paint chipping on the ceiling, the kitchen is in very good condition.

The importance of adequate cold holding, and sanitizing was emphasized. The Whirlpool dish washer had a sanitize text on the front for the cycles, but did not have the NSF/ANSI Standard 184 tag, and the establishment had no way of verifying the maximum temperatures reached in the dish washer. The sanitizer used in the kitchen, lemon scented Lysol multi surface cleaner, only reached 0-50 ppm for quaternary ammonium, which was not concentrated enough for use in the kitchen. The instructions on the Lysol also indicated, "…Do not use on eating / cooking utensils, glasses / dishes or cookware…" Due to the lack of sanitizing certification for the dish washer, and the instructions on the Lysol, I instructed Nicole to obtain a sanitizer, possibly a quaternary ammonium compound or a chlorine bleach solution, to use as a means to sanitize kitchen utensils and other kitchen wares until they are able to replace the dish washer. I also instructed Nicole to obtain the corresponding sanitizer test strips to test the sanitizer they obtain.

TCS items in the door but not the interior the of refrigerator measured above 41°F. Door items were discarded and I instructed Nicole to reduce the temperature in the refrigerator so that all items, even ones in the door, are maintained at 41°F or below.

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 1029221355 of 10/26/22.

Certified Food Protection Manager Nicole L. Aldes

Certification Number: FM107381 Expires: 06/22/24

Signed: _____

Nicole Aldes
LPN - Food Manager

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029221355

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	2	Date	10/26/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:00:58
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
The Maples	2823 7th Avenue North	Anoka, MN	55303	7637128363

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039167		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 10/27/22

Inspector (Signature)