Electronically Delivered

February 28, 2025

Licensee
Avalon Care
17946 Evening Lane
Lakeville, MN 55044

RE: Project Number(s) SL40290015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on January 22, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/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.

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40290	A. BUILDING: _____ B. WING _____	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE	17946 EVENING LANE LAKEVILLE, MN 55044

(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 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: SL40290015-0 On January 21, 2025, through January 22, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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

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0 470	Continued From page 2 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held a Provisional Assisted Living license. The facility was licensed for a capacity of five and had a current census of three residents receiving services. On January 21, 2025, at 11:30 a.m. during a facility tour, the surveyor reviewed the licensee's postings. No staff schedule was observed. Assisted living director in residency (ALDIR)-B stated he usually had the schedule printed and posted in a folder in his office. When ALDIR-B looked, he was unable to find a current schedule in the folder. ALDIR-B stated he was not aware he needed to post it for residents and visitors. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed	0 480		

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0 480	Continued From page 3 capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb	0 480		

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0 480	Continued From page 4 breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 22, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 5 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1's diagnoses included type 2 diabetes, anxiety, and depression. R1's Service Plan dated September 21, 2024, indicated he received the services of medication administration, blood sugar monitoring,	0 630		

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0 630	Continued From page 6 assistance with bathing, dressing, and transfers. On January 22, 2025, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R1 with checking his blood sugar, administer his oral medications, and assist with his insulin administration. R1's IAPP dated January 12, 2025, included his susceptibility to abuse by others and interventions to minimize the risks, but lacked the required content to include his susceptibility to abuse others including other vulnerable adults and include interventions to minimize the risk of abuse to others. On January 22, 2025, at 10:12 a.m., clinical nurse supervisor (CNS)-C stated she had not indicated his susceptibility to abusing others as she didn't feel he was susceptible to abusing others including other vulnerable adults. CNS-C stated she did not know the IAPP needed to clearly reflect whether he was susceptible to abusing others or not. The licensee's Abuse Prevention Plan policy dated August 1, 2021, indicated the plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults b. the person's risk of abusing other vulnerable adults, and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630		

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0 630	Continued From page 7 days	0 630		
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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements. Furthermore, the licensee failed to have the completed EP plan	0 680		

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0 680	Continued From page 8 readily accessible. 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 the residents). The findings include: On January 22, 2025, at 9:00 a.m., the surveyor reviewed the licensee's EP plan. The licensee's completed EP plan was stored in a locked closet and not readily available to staff or visitors. The plan included some basic content but lacked completeness or facility specific details with the plan. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z: - the licensee had a missing resident plan; however, had not reviewed on a quarterly basis; - policy and procedure addressing whether evacuated or shelter in place for staff/residents for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers;	0 680		

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0 680	Continued From page 9 - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional, and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); and - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to aid, to the authority having jurisdiction, the incident command center, or designee On January 22, 2025, at 11:50 a.m., assisted living director in residency (ALDIR)-B stated the licensee was still putting final touches on the licensee's emergency plan. ALDIR-B further stated he was not aware the plan needed to be available to staff and visitors. The licensee's Emergency preparedness policy dated August 1, 2021, indicated [licensee name] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 775	Continued From page 10	0 775		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code and Minnesota Rule 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: On January 22. 2025, from approximately 10:08 a.m. to 12:35 p.m., the surveyor toured the facility with assisted living director in residency (ALDIR)-B. During the tour, the surveyor observed the following: There was an unapproved receptable in the garage containing cigarette ash and discarded cigarettes. Cigarettes should be disposed of in approved receptacle that prevents ash and debris from escaping containment. Headboard of bed assembly in unoccupied resident room 4 was placed in front of egress window, obstructing egress. Egress windows	0 775		

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0 775	Continued From page 11 should be unobstructed to allow access to full openable area to permit egress in emergency evacuation. These deficient conditions were visually verified by ALDIR-B accompanying on the tour and ALDIR-B stated they understood requirements. TIME PERIOD FOR CORRECTION: Two (2) days.	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

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0 810	Continued From page 12 (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, and provide required training and documentation. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2025, at approximately 11:50 a.m., assisted living director in residency (ALDIR)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP was located in a locked cabinet and as such was not readily available to staff in an	0 810		

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	40290	A. BUILDING: _____ B. WING _____	01/22/2025

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0 810	Continued From page 13 emergency situation. The FSEP did not contain any documentation that included fire procedures for residents. FSEP did not include documentation showing that facility staff receive training on FSEP. Employees should receive training on FSEP at least upon hire and twice a year thereafter. The FSEP did not include adequate record of fire drills. The FSEP included information on two fire drills that occurred in 2024, but no other recorded fire drills were provided. ALDIR-B stated drills occur "every three months." Evacuation drills should occur at least once every other month and twice per year per shift. During the record review and interview on January 22, 2025, ALDIR-B verified the above listed documents were absent from the FSEP. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided;	01730		

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01730	Continued From page 14 (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individualized medication management plan reflected an accurate plan for one of one resident (R1) receiving medication administration services. This practice resulted in a level two violation (a	01730		

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01730	Continued From page 15 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: R1's diagnoses included type 2 diabetes, anxiety, and depression. R1's Service Plan dated September 21, 2024, indicated he received the services of medication administration. On January 22, 2025, at 7:05 a.m., the surveyor observed unlicensed personnel (ULP)-D prepare R1's insulin pen for R1 to self-administer. ULP-D stated once staff prepared the insulin pen, R1 liked to participate in part of his insulin administration by dialing the proper dose, showing staff the proper dose and self-injecting. ULP-D gathered the equipment and handed R1 an alcohol wipe to cleanse the area on his abdomen for administration. ULP-D obtained a new needle and attached the needle (without wiping the pen tip) to the pen and handed the insulin pen to R1. R1 then dialed the pen to the designated dose of 18 units and showed it to ULP-D. R1 self-administered the insulin, held the pen in place for several seconds and handed the pen back to ULP-D. R1's Medication Administration Record (MAR) dated January 2025, included one medication for blood thinning, one for cholesterol, two for allergies, three oral diabetes agents, one	01730		

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01730	Continued From page 16 diabetes injectable, one medication for high blood pressure, one for gastric reflux, one for enlarged prostate, one for sleep, three for anxiety/depression, one for cough, one for constipation, one for mild pain, one for erectile dysfunction, one eye drop for dry eyes, one topical cream for skin irritation, and one oral rinse for gum health. R1's Medication Plan (part of the RN comprehensive assessment) dated January 12, 2025, indicated R1 required full medication set up and administration. The licensee failed to indicate the steps R1 preferred for staff assistance in preparing the insulin pen, observation of R1 dialing to the proper dose and self-administration of his insulin. On January 22, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-C stated the licensee's ULP were previously administering R1's insulin and more recently, R1 requested to participate in self-administration while staff observed. CNS-C stated she had not updated R1's medication plan to reflect that change. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated the written Medication Management Plan included the following provisions: -a statement describing the medication management services to be provided -the Medication Management Plan will be kept current and updated with any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01750	Continued From page 17	01750		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-D) completed insulin administration via a prefilled insulin pen according to manufacturer instructions for one of one resident observed during insulin administration. 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: R1's diagnoses included type 2 diabetes, anxiety, and depression.	01750		

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01750	Continued From page 18 R1's Service Plan dated September 21, 2024, indicated he received the services of medication administration and blood sugar monitoring. R1's provider's orders dated October 14, 2024, indicated Lantus 100 units/milliliter (u/ml), inject 18 units subcutaneously (under the skin) once daily for diabetes management. On January 22, 2025, at 7:05 a.m., the surveyor observed ULP-D prepare R1's insulin pen for R1 to self-administer. ULP-D stated once staff prepared the insulin pen, R1 liked to participate in part of his insulin administration by dialing the proper dose, showing staff the proper dose and self-injecting. ULP-D gathered the equipment and handed R1 an alcohol wipe to cleanse the area on his abdomen for administration. ULP-D obtained a new needle and attached the needle (without wiping the pen tip) to the pen and handed the insulin pen to R1. R1 then dialed the pen to the designated dose of 18 units and showed it to ULP-D. R1 self-administered the insulin, held it in place for several seconds and handed the insulin pen back to ULP-D. The surveyor asked ULP-D if she had been trained to wipe the tip of the insulin pen prior to placing a new needle and about priming the insulin pen with the designated two units of insulin to prepare the pen for the proper dosage once the needle was attached. ULP-D stated sometimes she forgets to do these steps. On January 22, 2025, at 10:12 a.m., clinical nurse supervisor (CNS)-C stated she expected staff to wipe the insulin pen tip with an alcohol wipe prior to attaching a new needle and then prime the insulin pen with two units of insulin prior to handing the insulin to R1 to dial the appropriate	01750		

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01750	Continued From page 19 dose. Lantus Solostar manufacturer's instructions dated 2022, indicated: -wipe the insulin pen tip (rubber seal) with an alcohol wipe -attach a new needle -do a test dose of two units to prime the syringe and needle (removes air bubbles and brings insulin to the needle) -then dial the insulin pen to the prescribed dose and inject into the skin The licensee's Medication Administration policy dated August 1, 2021, indicated all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	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	01760		

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01760	Continued From page 20 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 medications were administered as ordered for one of three residents (R2) receiving medication 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 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 began receiving services under the facility's provisional Assisted Living Facility license on July 18, 2024. R2's diagnoses included depression, anxiety, COPD (chronic obstructive pulmonary disease-a chronic lung disease), and chronic pain. R2's Service Plan dated September 13, 2024, indicated he received the service of medication management.	01760		

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01760	Continued From page 21 R2's prescriber order dated October 9, 2024, indicated Diclofenac 1% gel, 2 grams (gm) to affected area three times daily for pain. On January 22, 2025, at 9:45 a.m. the surveyor observed unlicensed personnel (ULP)-D set up and administer medications for R2. ULP-D removed an unlabeled tube of Diclofenac gel from a zip-lock bag from R2's medication supply. ULP-D squeezed a small amount on her gloved index finger and applied to R2's chest area as he requested. The surveyor asked ULP-D how much she was supposed to administer and ULP-D stated about a finger-tip quantity. ULP-D was unable to find the measuring tool typically used to properly measure the Diclofenac gel. On January 22, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-C stated she was not sure where the measuring tool was to ensure R2's Diclofenac gel was dosed properly. The licensee's Medication Administration policy dated August 1, 2021, indicated the all staff with responsibility for medication administration have access to information about the medication being administered, including but not limited to: a. Purpose b. Dosage c. Route d. Frequency e. Instructions related to the medication and specific to the residents, as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		

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01880	Continued From page 22	01880		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications stored in a community refrigerator were securely stored (locked). 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 January 21, 2025, at 11:00 a.m. during entrance conference, clinical nurse supervisor (CNS)-C stated resident medications were securely stored in a locked medication closet and medications that required refrigeration were stored in the facility's community kitchen refrigerator. On January 21, 2025, at 2:15 p.m., the surveyor and unlicensed personnel (ULP)-D reviewed the medications stored in the kitchen refrigerator and noted the following:	01880		

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01880	Continued From page 23 -R1's Lantus Solostar insulin was stored in the refrigerator door compartment. The insulin was not secured and was accessible to other residents in the home. On January 21, 2025, at 2:20 p.m., clinical nurse supervisor (CNS)-B stated she had not thought about refrigerator medications and the need to protect them from other resident access. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated when [licensee name] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	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 ensure all	01890		

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01890	Continued From page 24 medications included a proper label for two of three residents (R1, R2). Furthermore, the licensee failed to ensure all time sensitive medications included an open date for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 included: R1 R1's Service Plan dated September 21, 2024, indicated he received the services of medication administration. R1's signed prescriber's orders dated October 14, 2024, indicated carboxymethylcellulose (Refresh) drops 0.5%, instill two drops in both eyes twice daily as needed for itchy eyes. On January 22, 2025, at 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-D set up and administer R1's oral medications. The surveyor noted a bottle of Refresh eye drops in R1's medication supply. The bottle lacked a label and an open date (the bottle appeared to have a broken seal indicating it was in use). R2 R2's Service Plan dated September 13, 2024, indicated he received the service of medication	01890		

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01890	Continued From page 25 management. R2's prescriber order dated October 9, 2024, indicated Diclofenac 1% gel, 2 grams (gm) to affected area three times daily for pain. On January 22, 2025, at 9:45 a.m., the surveyor observed ULP-D set up and administer medications to R2. ULP-D removed an unlabeled tube of diclofenac gel from a zip-lock bag from R2's medication supply. ULP-D squeezed a small amount on her gloved index finger and applied to R2's chest area as he requested. R2's diclofenac gel tube included only his name and an opened date; the package lacked a proper label with instructions for administration. On January 22, 2025, at 10:00 a.m., clinical nurse supervisor (CNS)-C observed R1 and R2's medications as listed above and confirmed the medications lacked a proper label. CNS-C stated R1's eye drops were recently provided by his eye doctor and did not come with a label and staff should indicate an open date. Refresh eye drops manufacturer's instructions dated March 2024, indicated discard eye drops after 90 days of use. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated as specified in the resident's medication management program, a licensed nurse will regularly set up medications in a clearly labeled container based on the resident's medication regimen. At this time, the nurse checks medication expiration dates and notes medications needing to be reordered. No further information was provided.	01890		

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01890	Continued From page 26 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/22/25*
Time: 09:50:00
Report: 1043251020

Food and Beverage Establishment Inspection Report

Location:
Avalon Care
17946 Evening Lane
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0044015
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/25

Operator:

Phone #: 6122420190
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.

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

NO DATE MARK OBSERVED ON OPENED BAG OF HOT DOGS IN FRIDGE. ADVISED STAFF TO DATE MARK TCS FOODS WHEN FIRST OPENED AND DISCARD LEFTOVERS AFTER 7 DAYS. FACT SHEET PROVIDED WITH REPORT. COMPLY WITH ABOVE RULE.

Comply By: 01/22/25

4-300 Equipment Numbers and Capacities

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

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

NO THIN PROBE THERMOMETER AVAILABLE TO MEASURE INTERNAL TEMPERATURE OF THIN FOODS COOKED IN HOUSE (EGGS, MEAT PATTIES, ETC). ADVISED STAFF TO PROVIDE AND MAINTAIN. COMPLY WITH ABOVE RULE.

Comply By: 01/22/25

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

NO DISH MACHINE TEST KIT AVAILABLE. ADVISED STAFF TO PROVIDE IRREVERSIBLE

THERMOMETER OR THERMOLABELS TO MEASURED UTENSIL SURFACE TEMPERATURE. SEE COMMENT FOR DETAILS. COMPLY WITH ABOVE RULE.

Comply By: 01/22/25

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

DRY INGREDIENTS (FLOUR, SUGAR, ETC) IN BULK CONTAINERS OBSERVED WITH NO LABELS IN THE DRY STORAGE ROOM. ADVISED STAFF TO PROVIDE LABELS WHEN INGREDIENTS ARE REMOVED FROM ORIGINAL PACKAGING. COMPLY WITH ABOVE RULE.

Comply By: 01/22/25

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12B

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

SCOOPS WITH HANDLES OBSERVED DOWN IN CONTACT WITH DRY INGREDIENTS (SUGAR, FLOUR, PANCAKE MIX, ETC) IN CONTAINERS IN DRY STORAGE ROOM. ADVISED STAFF TO POSITION HANDLES UPRIGHT IN BETWEEN USES TO PREVENT CONTAMINATION. COMPLY WITH ABOVE RULE.

Comply By: 01/22/25

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

BOX OF SPAGHETTI OBSERVED ON THE FLOOR IN THE DRY STORAGE ROOM. ADVISED STAFF TO RELOCATE FOOD AT LEAST 6 INCHES OFF THE FLOOR. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.

Comply By: 01/22/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

HANDLE BAR FOR FREEZER COMPARTMENT OBSERVED LOOSE. ADVISED STAFF TO REPAIR. COMPLY WITH ABOVE RULE.

Comply By: 01/22/25

Surface and Equipment Sanitizers

HOT WATER: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 46 Degrees Fahrenheit - Location: COOLING FROM AMBIENT
Violation Issued: No

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	3	4

Inspection was completed with Deb Jacobson as the lead Health Regulation Division Nurse Evaluator completing the site survey.

Discussed highly susceptible populations, date marking, illness policy, sanitizer use, ware washing, temperature control, cleaning, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Foods cooked in house must be fully cooked (exception for pasteurized eggs) and must only be available for same day service for highly susceptible populations, discard any leftovers by the end of the day.

This facility has a residential kitchen with residential equipment and wooden cabinetry. Utensil surface temperature of dish machine must reach at least 160F degrees (or 150F degrees for NSF/ANSI 184 residential dish machine). Sanitizing option on dish machine must always be used when running a cycle.

Contact Health Regulation Division for plan review approval when facility/kitchen undergoes remodeling.

***Notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation.

If any customer complains of illness, establishment is required to notify the Minnesota Department of Health and provide the foodborne illness hotline phone number to the customer: 1-877-366-3455

Type: Full
Date: *01/22/25*
Time: 09:50:00
Report: 1043251020
Avalon Care

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 1043251020 of 01/22/25.

Certified Food Protection Manager: Halimo A. Yusuf

Certification Number: FM122355 Expires: 03/01/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Abdi Abukar
PIC

Signed: _____
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us