Electronically Delivered

July 6, 2023

Licensee
Chestnut Grove
1204 West Chestnut Street
Virginia, MN 55792

RE: Project Number(s) SL20288016

Dear Licensee:

On June 20, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 13, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 13, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on April 13, 2023, found not corrected at the time of the June 20, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0680 - Disaster Planning And Emergency Preparedness - 144g.42 Subd. 10 - $500.00
1890 - Prescription Drugs - 144g.71 Subd. 20

The details of the violations noted at the time of this follow-up survey completed on June 20, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

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

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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.

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	R 06/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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 SL20288016-1 On June 20, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 13, 2023. At the time of the survey, there were 20 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}		

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{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	{0 680}		

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{0 680}	Continued From page 2 by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all required content, or practice and document testing of the plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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's Assisted Living with Dementia Care Emergency Management Plan revised August 1, 2022, lacked the following content and/or policies and procedures to address: -subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal; -a policy to address the use of volunteers, including the process/role for integration; and -participation in annual full-scale community or facility-based exercises twice a year and documenting testing of the emergency plan. On June 20, 2023, at 1:13 p.m., licensed assisted living director (LALD)-A stated she had not made any updates to the licensee's emergency plan since the previous survey on April 13, 2023. LALD-A confirmed the EPP lacked the content	{0 680}		

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{0 680}	Continued From page 3 noted above and the licensee had not participated in or scheduled any tabletop, full-scale community or facility wide or exercises. The licensee's Emergency Preparedness Plan-Appendix Z Compliance dated July 9, 2022, indicated the licensee's would align with the Centers for Medicare and Medicaid Services Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." The licensee's emergency preparedness plan would include all required elements of appendix Z. No further information was provided.	{0 680}		
{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: No further action required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	{0 810}		

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{0 810}	Continued From page 4 (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: No further action required.	{0 810}		
{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	{01890}		

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{01890}	Continued From page 5 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened or expiration dates for R8, R11. 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: On June 20, 2023, at 12:31 p.m., the surveyor observed the East/West medication cart with licensed practical nurse (LPN)-C. LPN-C confirmed the following: -R8's opened Breo Ellipta inhaler (used to treat asthma) lacked the date the inhaler had been opened and when the inhaler would expire. -R11's opened latanoprost eye drop (used to treat high pressure in the eye) lacked the date the eye drop was opened and when the eye drop would expire.	{01890}		

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{01890}	Continued From page 6 On June 20, 2023, 1:05 p.m., clinical nurse supervisor (CNS)-B stated LPN-B was assigned to complete weekly medication cart audits looking for expired medications and to ensure all time sensitive medications had the date the medicaion was opened and would expire. The manufacturer's instructions for Breo Ellipta inhaler revised January 2019, indicated to write the date the tray was opened and would expire on the inhaler label and discard six (6) weeks after opened. The manufacturer's instructions for latanoprost (Xalatan) eye drop dated August 2011, indicated once the bottle is opened it may be stored at room temperature up to six (6) weeks. The licensee's Medications Storage policy dated July 12, 2022, indicated medication would be stored consistent with the manufacturer's recommendations. No further information was provided.	{01890}		

Electronically Delivered

April 24, 2023

Licensee
Chestnut Grove
1204 West Chestnut Street
Virginia, MN 55792

RE: Project Number(s) SL20288016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 MDH imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH 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 MDH

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 survey:

St - 0 - 1420 - 144g.62 Subd. 2 - Delegation Of Assisted Living Services = $3,000
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement = $3,000

The total amount you are assessed is $6,000. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been 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: SL20288016 On, April 11, 2023, through April 13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were 20 residents receiving services under the Assisted Living with Dementia license. Immediate correction orders were identified on April 12 and 13, 2023, issued for SL20288016, tag identification 1420 and 2070. On April 13, 2023, the immediacy of correction orders 1240 and 2070 were removed, however non-compliance remained for each tag at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 18 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 29, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

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0 550	Continued From page 2 procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure. In addition, the licensee's grievance procedure did not include the email contact information for the individuals who are responsible for handling grievances. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on April 11, 2023, at 11:21 a.m., with licensed assisted living director	0 550		

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	20288	A. BUILDING: _____ B. WING _____	04/13/2023

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0 550	Continued From page 3 (LALD)-A, and clinical nurse supervisor (CNS)-B, LALD-A confirmed the main entrance and/or common areas lacked the required posting of the grievance procedure. LALD-A stated the grievance procedure was normally posted at the front entrance with all the other postings. LALD-A provided the surveyor with the licensee's grievance procedure, and LALD-A confirmed the grievance procedure did not include the e-mail contact information for the individuals who are responsible for handling resident grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
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	0 680		

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0 680	Continued From page 4 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all required content, or practice and document testing of the plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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's Assisted Living with Dementia Care Emergency Management Plan revised August 1, 2022, lacked the following content and/or policies and procedures to address: -subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal; -a policy to address the use of volunteers, including the process/role for integration; and -participation in annual full-scale community or	0 680		

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0 680	Continued From page 5 facility-based exercises twice a year and documenting testing of the emergency plan. On April 13, 2023, at 3:10 p.m., licensed assisted living director (LALD)-A confirmed the licensee's emergency plan lacked the content noted above and the licensee had not participated in any tabletop, full-scale community or facility wide or exercises. The licensee's Emergency Preparedness Plan-Appendix Z Compliance dated July 9, 2022, indicated the licensee's would align with the Centers for Medicare and Medicaid Services Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." The licensee's emergency preparedness plan would include all required elements of appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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	0 800		

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0 800	Continued From page 6 by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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). Findings include: On a facility tour on April 11, 2023, at approximately 10:30 p.m. with maintenance manager (M)-D it was observed that the marked exit doors leading into the front vestibule from each wing of the building had numerical keypad locked doors that did not fail safe upon activation of the sprinkler or alarm system or loss of power. It was also observed that a dryer vent was allowing exhaust to be discharged into the laundry room in the laundry room in the northwest side of the facility of the building. Dryer vent exhaust is required to be directed to the exterior of the building. An exterior gate was observed with lockable padlock hardware and did not include egress hardware for exiting from both secured exterior courtyards. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the	0 800		

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0 800	Continued From page 7 same as the building exterior exit doors. It was observed the gate keypad magnetic lock release was not working on the gate from the southwest courtyard leading to the public way. Gates or doors in the exterior exit path to the public way are required to operate for egress to the public way. It was observed the boiler room/ water heater room in the south wing of the building was not provided with combustion air for the fuel burning appliances. The water heater was observed with a build up of salt deposits on top of the heater near the draft hood. Fuel burning appliances are required to be provided with combustion air for safe operation. Holes in the fire-resistant rated wall were observed in the south wing boiler/ water heater room. Fire-resistant rated walls and assemblies are required to be maintained as designed and constructed. Water damage was observed on drywall of the fire-resistant rated walls around the water softer in the south wing boiler/ water heater room. Fire-resistant rated walls and assemblies are required to be maintained as designed and constructed. It was observed that a marked exterior exit door in the southwest corner of the south wing was very hard to open. Marked exit doors are required to operate freely in order to not impede immediate use for exiting. It was observed some of the carbon monoxide alarms were not re-installed after painting in the corridors. Carbon Monoxide alarms are required	0 800		

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0 800	Continued From page 8 to be maintained within 10' of all sleeping rooms. These deficient conditions were visually verified by M-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the 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	0 810		

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0 810	Continued From page 9 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 maintain the facility's fire safety and evacuation plan with required elements. 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). A record review of available documentation and interview were conducted on April 11, 2023, at approximately 12:30 p.m. of documents provided by licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation	0 810		

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0 810	Continued From page 10 indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. All deficiencies were verified by LALD-A during the interview at approximately 1:00 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01420 SS=I	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by:	01420		

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01420	Continued From page 11	01420		

Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for delegated tasks to include the use of a sit to stand lift (a mechanical device to aide in transfer of persons with limited weight bearing ability) for three of three unlicensed personnel (ULP)-E, ULP-H, ULP-I). This practice resulted in an immediate correction order on April 13, 2023, at approximately 12:45 p.m.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

ULP-E

ULP-E was hired April 3, 2023, to provide direct care services to the licensee's residents.

ULP-E's record indicated licensed practical nurse (LPN)-C conducted ULP's training and competency evaluation for the use of the sit to stand on April 10, 2023.

ULP-H

ULP-H was hired January 9, 2023, to provide direct care services to the licensee's residents.

ULP-H's record indicated licensed practical nurse

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01420	Continued From page 12 LPN-C conducted ULP's training and competency evaluation for the use of the sit to stand on January 25, 2023. On April 12, 2023, at the evaluator observed ULP-H transfer R2 from her wheelchair to the toilet and back into her wheelchair using a sit to stand lift. ULP-I ULP-I was hired October 21, 2022, to provide direct care services to the licensee's residents. ULP-I's record indicated licensed practical nurse LPN-C conducted ULP's training and competency evaluation for the use of the sit to stand on November 9, 2022. On April 13, 2023, at 8:55 a.m., LPN-C stated she completes ULPs training on the sit to stand for the licensee and other areas the RN may not have been able to complete. LPN-C confirmed she had completed the training and competency evaluations for ULP-E, ULP-H, and ULP-I in the use of the sit-to-stand. On April 13, 2023, at 9:17 a.m., the evaluator observed ULP-I transfer R2 from her wheelchair to the toilet and back into her wheelchair using a sit to stand lift. On April 13, 2023, at 9:28 a.m., ULP-I stated she was trained, and competency tested at the facility by LPN-C on the use of the sit to stand. On April 13, 2023, at 9:45 a.m., clinical nurse supervisor (CNS)-B stated the RN completed the ULP's training and competency testing at another facility site and did not train on the use of the sit	01420		

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01420	Continued From page 13 to stand because the facility where the training took place, did not have a sit to stand to use for training. CNS-B stated the licensee's ULPs were trained at the facility by LPN-C because R2 had her own sit to stand to use for training. CNS-B stated it was her understanding if the RN deemed the LPN was competent, the LPN could conduct ULP's training and competency testing if working under the direction of the RN, even if the RN was not in the building or providing direct supervision of the LPN. The licensee's Competency Training Evaluations policy dated July 12, 2022, indicated when a registered nurse or licensed health professional staff of the licensee delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. A registered nurse, or another instructor may provide training in conjunction with the registered nurse and will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor's on-site observation and review by evaluation supervisor on April 13, 2023, however, non-compliance remains at a scope and level of level three, widesrpead (I).	01420		

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01620	Continued From page 14	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment not to exceed day 90 for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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01620	Continued From page 15 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included alcohol related dementia with behavioral disturbances, schizophrenia, degenerative joint disease, mild intellectual disability, and hearing loss of left ear. R3's Service Plan dated April 27, 2022, indicated R3's services included medication management, bathing, dressing, grooming, toileting, behavior management, supervised smoking, laundry and housekeeping. R3's 90-Day Assessments were completed on January 3, 2023, and April 11, 2023, for a total of 98 days in between assessments. On April 13, 2023, at 2:12 p.m., clinical nurse supervisor (CNS)-B verified R3's 90-day assessment was not completed within the required timeframe. The licensee's Assessments, Reviews, and Monitoring Policy dated August 1, 2022, indicated 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. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01620		

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01750	Continued From page 16	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 the registered nurse (RN) prepared in writing specific instructions for one of two residents (R3) who received medication management. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included alcohol related dementia with behavioral disturbances, schizophrenia, degenerative joint disease, mild intellectual	01750		

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	20288	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

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01750	Continued From page 17 disability, and hearing loss of left ear. R3's Service Plan dated April 27, 2022, indicated R3 services included medication management. R3's prescriber orders dated January 16, 2023, included Advair HFA (used to treat asthma) 115-21 micrograms (mcg) inhale two (2) puffs into lungs twice a day, shake well, rinse mouth after use. R3's April 2023, medication administration record (MAR) indicated R3 received Advair HFA 115-21 mcg and directed to inhale two (2) puffs into lungs twice a day, shake well, rinse mouth after use. R3's MAR lacked specific written instructions for the use of the inhaler to include: to instruct the resident to take a breath and let it out, begin to breathe in slowly, and then compress the inhaler to release the medication. Hold breath for 5-10 seconds to allow medication to reach deeply into lungs. Wait at least one (1) minute in between puffs of same medication. On April 12, 2023, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-I administer R3's inhaler. ULP-I approached R3 explained to R3 it was time for her inhaler and medications. ULP-I shook the inhaler, removed the cap from the inhaler, R3 opened her mouth and ULP-I consecutively administered 2 puffs of the medication directly into R3's mouth. ULP-I did not instruct R3 to inhale during each administration of the medication, wait one (1) minute in between puffs or instruct R3 to rinse out her mouth after the administration of the inhaler. After the administration of R3's inhaler, ULP-I confirmed R3's MAR did not instruct to have R3 hold her breath after each puff or wait one minute in between puffs.	01750		

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01750	Continued From page 18 On April 13, 2023, at 2:17 p.m., clinical nurse supervisor (CNS)-B stated when administering inhalers, staff were expected to shake the inhaler, instruct resident to inhale during the administration of the inhaler, wait one minute in between puffs and rinse mouth after use. CNS-B confirmed R3's MAR did not include complete written instructions on the use of the inhaler to include instructing the resident to hold their breath or wait at least one (1) minute in between puffs of the inhaler. The licensee's Inhaler policy dated July 12, 2022, indicated to remove cap from mouthpiece, shake the inhaler for 5-10 seconds, position inhaler upside down with mouthpiece on the bottom. Place the resident in an upright position and tilt the head back slightly and breathe out. Instruct the resident to the number of puffs ordered and to close their mouth around the mouthpiece. Instruct the resident to take a breath and let it out, begin to breathe in slowly, and then compress the inhaler to release the medication. Hold breath for 5-10 seconds to allow medication to reach deeply into lungs. Wait at least one (1) minute in between puffs of same medication. Provide resident the opportunity to rinse out mouth. 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	01760		

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01760	Continued From page 19	01760		

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 medications were administered as prescribed and administered according to manufacturer's instructions for one of two residents (R3).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3's diagnoses included alcohol related dementia with behavioral disturbances, schizophrenia, degenerative joint disease, mild intellectual disability, and hearing loss of left ear.

R3's Service Plan dated April 27, 2022, indicated R3 services included medication management.

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01760	Continued From page 20 R3's prescriber orders dated January 16, 223, included Advair HFA (used to treat asthma) 115-21 micrograms (mcg) inhale two (2) puffs into lungs twice a day, shake well, rinse mouth after use. R3's April 2023, medication administration record (MAR) indicated R3 received Advair HFA 115-21 mcg and directed to inhale two (2) puffs into lungs twice a day, shake well, rinse mouth after use. On April 12, 2023, at 7:38 a.m., the surveyor observed unlicensed personnel (ULP)-I administer R3's inhaler. ULP-I approached R3 explained to R3 it was time for her inhaler and medications. ULP-I shook the inhaler, removed the cap from the inhaler, R3 opened her mouth and ULP-I consecutively administered 2 puffs of the medication directly into R3's mouth. ULP-I did not instruct R3 to inhale during each administration of the medication, wait one (1) minute in between puffs or instruct R3 to rinse out her mouth after the administration of the inhaler. After the administration of R3's inhaler and oral medications, ULP-I confirmed R3's MAR instructed to rinse mouth after the use of the inhaler. ULP-I stated R3's MAR did not instruct to wait one (1) minute between puffs and she didn't have R3 rinse her mouth after using the inhaler because R3 had water with her pills. On April 13, 2023, at 2:17 p.m., clinical nurse supervisor (CNS)-B stated when administering inhalers, staff were expected to shake the inhaler, instruct resident to inhale during the administration of the inhaler, wait one minute in between puffs of the medicine and rinse mouth after use.	01760		

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01760	Continued From page 21 The manufacturer's directions for Advair HFA inhaler dated July 2022, directed to push the top of the metal canister all the way down while you breathe in deeply and slowly through your mouth. After you have breathed in all the way, take the inhaler out of your mouth and close your mouth. Hold your breath for about 10 seconds, or for as long as is comfortable. Breathe out slowly as long as you can. Wait about 30 seconds and shake the inhaler well for 5 seconds. Repeat steps 2 through 6. Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. The licensee's Inhaler policy dated July 12, 2022, indicated to remove cap from mouthpiece, shake the inhaler for 5-10 seconds, position inhaler upside down with mouthpiece on the bottom. Place the resident in an upright position and tilt the head back slightly and breathe out. Instruct the resident to the number of puffs ordered and to close their mouth around the mouthpiece. Instruct the resident to take a breath and let it out, begin to breathe in slowly, and then compress the inhaler to release the medication. Hold breath for 5-10 seconds to allow medication to reach deeply into lungs. Wait at least one (1) minute in between puffs of same medication. Provide resident the opportunity to rinse out mouth. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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	01890		

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01890	Continued From page 22 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened or expiration dates for R3, R8, R9. In addition, the licensee failed to monitor for expired medications for R10. 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: TIME SENSITIVE MEDICATIONS On April 11, 2023, at 11:46 a.m., the surveyor observed the East/West medication cart with clinical nurse supervisor (CNS)-B. CNS-B confirmed the following: -R8's opened Breo Ellipta inhaler (used to treat asthma) lacked the date the inhaler had been opened and when the inhaler would expire. -R9's opened Spiriva inhaler (used to treat bronchospasms) lacked the date the inhaler had been opened and when the inhaler would expire. On April 11, 2023, 11:56 a.m., the surveyor observed the North/South medication cart with CNS-B. CNS-B confirmed the following:	01890		

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01890	Continued From page 23 -R3's opened Spiriva inhaler lacked the date the inhalers had been opened and when the inhalers would expire. EXPIRED MEDICATION -R10's opened nystatin powder had expired on November 10, 2022. On April 11, 2023, 12:08 p.m., CNS-B confirmed time-sensitive medications such as inhalers, eye drops and insulins, should be dated after opening to include the date the medications would expire. CNS-B stated the licensee had stickers to place on time sensitive medications which included an area to write the opened and expiration date. CNS-B stated the LPN was to maintain the medication carts to ensure medications were dated and were not expired. CNS-B stated the licensee did not have a formal auditing schedule in place for monitoring the medication carts. The manufacturer's instructions for Breo Ellipta inhaler revised January 2019, indicated to write the date the tray was opened and would expire on the inhaler label and discard six (6) weeks after opened. The manufacturer's instructions for Advair inhaler dated January 2019, indicated to discard one month after opening foiled pouch. The manufacturer's instructions for Spiriva inhaler revised November 2021, indicated to discard three months after insertion of cartridge, throw away the Spiriva Respimat even if it has not been used. The licensee's Medications Storage policy dated July 12, 2022, indicated medication would be stored consistent with the manufacturer's	01890		

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01890	Continued From page 24 recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R1) upon discharge.	01910		

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01910	Continued From page 25 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 finding include: R1 was discharged on April 6, 2023. R1's March 2023, Medication Administration Summary indicated R1 received the following medications: -levothyroxine (treats underactive thyroid) 25 micrograms 1/2 tablet daily; -aspirin 81 mg tablet daily; -losartan (treats high blood pressure) 50 mg one tablet daily; -quetiapine (treats mental health disorders) 100 mg one tablet twice a day; -rivastigmine (improves mental function) 4.6 mg patch daily; and -quetiapine 50 mg tablet daily; R1's Discharge - Transfer Summary dated April 9, 2023, noted medications were destroyed April 7, 2023. In addition, the summary noted R1 received assistance with medication management including administration. The summary included a Medication Disposition Summary, which noted disposition of medications to include the medication name, quantity, and strength, and prescription numbers; however, lacked the disposition of quetiapine 100 mg tables.	01910		

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01910	Continued From page 26 On April 11, 2023, at 10:11 a.m., clinical nurse supervisor (CNS)-B confirmed R1's March 2023 MAR indicated R1 was taking quetiapine 100 mg tablet twice a day. CNS-B confirmed R1's disposition of medication summary did not include the disposition of R1's quetiapine 100 mg tablets. CNS-B stated R1's quetiapine had just come in from the pharmacy had been used and was sent back to the pharmacy for credit. CNS-B confirmed R1's record should have indicated the disposition of R1's quetiapine 100 mg tablets. The licensee's Medication Disposal policy dated July 12, 2022, indicated upon disposition, the licensee must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12).	02070		

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02070	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in two of two secured units North/South-(N/S) and East/West-(E/W). This had the potential to affect all 20 residents residing in the secured units. This practice resulted in an immediate correction order on April 11, 2023, at approximately 2:45 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license with a capacity of 20 residents and had a current census of 20 residents. The physical layout of the facility consisted of two (2) secured memory care units separated by the main foyer in the entrance of the facility. Both units were secured with a coded keypad for exiting the units. On April 11, 2023, at 9:59 a.m., during entrance conference, licensed assisted living director	02070		

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02070	Continued From page 28 (LALD)-A stated there were two (2) unlicensed personnel (ULP) scheduled for each shift and there were open float positions for each shift. Clinical nurse supervisor (CNS)-B stated during the week, licensed practical nurse (LPN)-C was scheduled to work Monday through Friday from 7:00 a.m. to 3:00 p.m. and administrator assistant (AA)-J was on the schedule from 8:00 a.m., to 4:00 p.m., Monday through Friday. LALD-A stated AA-J assisted with administrative duties as well as filled in as an ULP when needed. CNS-B stated there was no third ULP that floated in between units at this time and the position had been open on and off and for periods of time. CNS-B confirmed there were no residents that required a two person transfer. On April 11, 2023, at 3:25 p.m., ULP-E stated during her training on E/W unit with ULP-K, both ULP-E and ULP-K had to leave E/W unit unattended to assist on N/S unit because R4 would not take her medications. ULP-E stated staff were able to leave the units if needed for short periods to assist on the other unit, gather supplies and use the bathroom. On April 11, 2023, at 3:51 p.m., the evaluator observed ULP-E leave N/S unit and enter E/W unit. The surveyor immediately entered N/S unit and there was one resident standing by the medication cart and another resident sitting outside in the courtyard, no other staff were observed on the unit. At 3:54 p.m., ULP-E returned to N/S unit. ULP-E stated she was called to assist with "boosting up" R5. At 3:57 p.m., ULP-E was observed leaving N/E unit unattended while going outside for the residents supervised scheduled smoking times and stayed with the residents until 4:03 p.m. ULP-E stated the scheduled smoking times on N/E were at 4:00	02070		

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02070	Continued From page 29 p.m., 5:30 p.m., 7:00 p.m., 8:30 p.m., and 10:00 p.m. On April 11, 2023, at 4:16 p.m., ULP-L stated she normally worked the evening shift and there were only two staff scheduled during the shift. ULP-L stated staff left the secured units to assist on the other units either for behavior intervention, repositioning or if a resident fell and could not get up with one person assist. ULP-L stated the scheduled smoking times on E/W in the evening shift were 3:30 p.m., 5:00 p.m., 6:30 p.m., 8:00 p.m., and 9:30 p.m. On April 12, 2023, at 6:17 a.m., the evaluator entered the facility. At 6:21 a.m., the evaluator observed ULP-F leave N/S unit and enter E/W unit. At 6:25 a.m., ULP-F stated there were only two staff scheduled on the night shift. ULP-F stated staff left their units about two to five times a night to help each other out with residents having behaviors, stocking the units or use the bathroom. ULP-F stated it was okay to leave the units unattended for short periods of time when needed. On April 12, 2023, at 6:45 p.m., ULP-F stated the night shift was responsible for stocking each unit. ULP-F stated she had to leave E/W unit to get cleaning supplies from N/S unit and food items from the foyer. ULP-F stated staff could be gone anywhere from five to 20 minutes at a time. On April 12, 2023, at 6:49 a.m., ULP-G stated she normally worked the night shift and usually left the secured unit to use the bathroom, stock the unit with supplies, or assist with redirecting residents with increased behaviors. On April 12, 2023, at 7:55 a.m., ULP-I stated she	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20288	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT GROVE	1204 WEST CHESTNUT STREET VIRGINIA, MN 55792

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02070	Continued From page 30	02070		

would have to leave N/S unit to assist on E/W to assist in repositioning R-5, assisting with falls, or gathering food supplies. ULP-I stated she was never informed she was never to leave the unit without another staff being present.

On April 12, 2023, at 8:12 a.m., AA-J stated was responsible for staff scheduling. AA-J stated each shift should have a float and were currently trying to fill the positions. AA-J stated they have been without floats for about a month or two.

On April 12, 2033, at 8:36 a.m., the evaluator observed ULP-I outside in the courtyard supervising residents smoking on N/S unit. N/S unit was left unattended until AA-J entered at 8:39 a.m.

On April 12, 2023, at 10:17 a.m., CNS-B stated staff were not to leave the secured units unattended. If staff needed to leave the secured units for any reason, staff were instructed to prop open each of the secured doors of the units, which was safe to do since the main entrance door was secured. CNS-B stated during the residents scheduled smoking times, staff were expected to use the walkie talkies to notify when it was time for the residents to go out and smoke so staff would know they were going outside with the residents. During resident scheduled smoke times, staff were expected to completed safety checks on all residents who did not go outside to smoke before they left the secured unit to bring the residents into the courtyard. CNS-B stated during the day shift, there were extra staff to cover for smoke times and confirmed on weekends, afternoons, and night shift, there was no third staff to assist with smoking times.

On April 12, 2023, at 10:31 a.m., LALD-A and

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	20288	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02070	Continued From page 31	02070		

CNS-B observed the secured doors to each of the secured units which both needed to be propped open to remain open and there were no door stoppers near the doors. LPN-C exited the office located of the foyer between the secured units and handed two (2) door stoppers to CNS-B. CNS-B confirmed there were no door stoppers available for staff to prop open the doors. While observing the secured doors, ULP-G exited the north/south secured unit, walked past LALD-A, CNS-B and the evaluator and entered E/W secured unit. The evaluator requested CNS-B to observe the N/S unit with the evaluator to see if the secured unit was left unattended. LALD-A, CNS-B observed N/S unit and confirmed, N/S secured unit was left unattended. At 10:34 a.m., ULP-G returned to N/S unit with a loaf of bread.

The Night Shift Timeline sheet, indicated from 2:00 a.m. to 4:00 a.m., the night staff were to stock medication carts with water cups and medication cups and to stock napkins and condiment drawers, etc.

The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated March 13, 2023, indicated the number of ULPs typically scheduled per shift were three (3) ULPs on days, two (2) ULPs on evenings, and (2) ULPs on nights.

The licensee's undated Smoking/Vaping policy indicated residents who require supervision to smoke safely, staff would accompany the resident to the outdoor smoking area and assist the resident to light and extinguish cigarettes (or other tobacco products) appropriately and safely. Staff would maintain a smoking schedule for supervised smoking through the day from 8:00

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	20288	A. BUILDING: _____ B. WING _____	04/13/2023

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02070	Continued From page 32 a.m. to 10:00 p.m., and will honor the requests of the residents as needed between scheduled smoking times. After 10:00 p.m., any resident that required supervision to smoke would be escorted to the designated smoking area, supervised and assisted with lighting and extinguishing smoking materials. While staff accompany the resident to the designated smoking area outdoors, staff would communicate to the other staff member on duty that they would be outside and require them to monitor activities on the unit while staff were outside with the smoking resident. The licensee's Staffing and Scheduling policy dated July 9, 2022, indicated qualified employees would be scheduled to meet the operational requirements and the needs of the residents. The policy indicated the CNS would develop and implement a written staffing plan to ensure that staffing levels were adequate to address each residents needs 24-hours a day, seven days a week. The licensee's Staffing Plan dated August 31, 2022, indicated the following staff requirements needed to meet current resident needs were the following: -LALD Monday, Wednesday, Friday and as needed from 8:00 a.m., to 12:00 p.m., as needed; -registered nurse Monday, Wednesday, Friday and as needed from 8:00 a.m., to 4:00 p.m.; -facility manager Monday through Friday from 7:00 a.m., to 3:30 p.m., -licensed practical nurse Monday through Friday from 7:00 a.m., to 3:30 p.m., -facility manager Monday through Friday from 7:00 a.m., to 3:30 p.m., -three (3) ULPs 7 days a week from 7:00 a.m., to 3:30 p.m.;	02070		

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02070	Continued From page 33 -three (3) ULPs 7 days a week from 3:00 p.m. to 11:30 p.m.; -three (3) ULPs 7 days a week from 11:00 p.m. to 7:30 a.m.; and -housekeeping, Monday, Friday, Saturday, and Sunday from 8:00 to 2:00 p.m. On April 12, 2023, at 12:10 p.m., LALD-A stated they do not have a housekeeper as indicated in the Staffing Plan dated August 31, 2022. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by surveyor's on-site observation and review by evaluation supervisor on April 13, 2023, however, non-compliance remains at a scope and level of level three, widesrpead (I).	02070		
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the	02170		

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02170	Continued From page 34 resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a comprehensive evaluation for activities and an individual activity plan (IAP) for one of two residents (R3) who received services under an assisted living with dementia care license. 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).	02170		

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02170	Continued From page 35 The findings include: R3's diagnoses included alcohol related dementia with behavioral disturbances, schizophrenia, degenerative joint disease, mild intellectual disability, and hearing loss of left ear. R3's Service Plan dated April 27, 2022, indicated R3 services included medication management, bathing, dressing, grooming, toileting, behavior management, supervised smoking, laundry, and housekeeping. R3's 90-Day Assessment dated April 11, 2023, indicated R3's behaviors included physical and verbal aggression, paranoia and R4 was impatient. R3's IAP dated April 11, 2023, lacked identification of activities for behavioral interventions. On April 12, 2023, at 3:55 p.m., clinical nurse supervisor (CNS)-B stated they have been discussing the activity evaluations to improve on making the resident's activity plans more individualized. CNS-B confirmed R3's activity evaluation and plan did not identify R3's activities for behavioral interventions. The licensee's ALDC Life Enrichment Programs, Activities and Outdoor Spaces dated July 9, 2022, indicated each resident would be evaluated for activities according to the licensing rules of the facility that would address the following: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to	02170		

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02170	Continued From page 36 participate; and -identification of activities for behavioral interventions; and an individualized activity plan must be developed for each resident based on their activity evaluation and must reflect the resident's activity preferences and needs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: *04/11/23*
Time: 09:45:04
Report: 1032231064

Food and Beverage Establishment Inspection Report

Location:
Chestnut Grove - East
1204 West Chestnut Street
Virginia, MN55792
St. Louis County, 69

Establishment Info:
ID #: 0027658
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Range Development Co. of Chish

Phone #: 2182639220
ID #: 27479

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-602.11A ***** Priority 1 *****

MN Rule 4626.0845A Clean and sanitize food-contact surfaces of equipment and utensils: 1. before each use with a different type of raw animal food; 2. each time there is a change from working with raw foods to working with ready-to-eat foods; 3. between uses with raw fruits and vegetables and TCS foods; 4. before using or storing a food temperature measuring device; 5. at any time during the operation when contamination may have occurred.

CUTTING BOARD AND OVEN MITS HAD FOOD RESIDUE ON THEM, CLEAN BETWEEN USE

Comply By: 04/14/23

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

SILVERWARE DRAWER WAS SOILED WITH FOOD DEBRIS AND NEEDS TO BE CLEANED

Comply By: 04/14/23

4-200 Equipment Design and Construction

4-204.112E ***** Priority 2 *****

MN Rule 4626.0620E Provide food and water temperature measuring devices that are numerically scaled in increments no greater than 2 degrees F.

NO THIN PROBED THERMOMETER ON SITE

Comply By: 04/18/23

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

3-304.12A

MN Rule 4626.0275A Store food preparation or dispensing utensils in the food with the handles above the top of the food within the container.

SCOOP HANDLE IN FLOUR WAS TOUCHING THE PRODUCT, SCOOP REMOVED

Corrected on Site

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

FOOD LEFT ON COUNTER TO THAW, MOVED TO REFRIGERATOR

Corrected on Site

Food and Equipment Temperatures

Process/Item: Receiving
Temperature: Degrees Fahrenheit - Location: FROZEN
Violation Issued: No

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

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: LEMON BARS
Violation Issued: No

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

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

Breakfast is the only meal prepared on site. There is one food delivery a day, from Hillcrest Adams, and that contains frozen meals for lunch and dinner.

Explained proper thawing procedure, which is under mechanical refrigeration and discontinuing thawing foods on the counter.

Report reviewed with manager Holli. Potential hazards in day-to-day operation were discussed, including employee illness, excluding/restricting employees experiencing illness symptoms, recording employee illness symptoms.

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 MDH inspection report number 1032231064 of 04/11/23.

Certified Food Protection Manager: HOLLI M JOHNSON

Certification Number: FM62527 Expires: 06/05/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

HOLLI M JOHNSON
KITCHEN MANAGER

Signed: 

Ben Kubes
Environmental Health Specialist
Duluth
ben.kubes@state.mn.us

Report #: 1032231064

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH

11 E Superior Street
Duluth

No. of RF/PHI Categories Out	1	Date	04/11/23
No. of Repeat RF/PHI Categories Out	0	Time In	09:45:04
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Chestnut Grove - East	1204 West Chestnut Street	Virginia, MN	55792	2182639220

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0027658	Range Development Co. of Chish	Full		L

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	X	
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43	X	In-use utensils: properly stored	X	
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		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:** 04/12/23

Inspector (Signature)