Electronically Delivered

February 21, 2025

Licensee
Legacy Place LLC
902 15th Street Northeast
Sauk Rapids, MN 56379

RE: Project Number(s) SL31437016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31437	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY PLACE LLC	902 15TH STREET NE SAUK RAPIDS, MN 56379

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31437016 On January 13, 2025, through January 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were eight (8) residents receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 13, 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		

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0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (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 develop and implement an individual abuse prevention plan (IAPP) to contain all the required information 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: On January 14, 2025, at 8:19 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1.	0 630		

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0 630	Continued From page 4 R1 was admitted to the licensee on May 31, 2024, with diagnoses including dementia. R1's Service Plan dated May 31, 2024, indicated R1 received services including Toileting, dressing, grooming, oral care, bathing assist, behavior mood, medication administration, safety check, housekeeping, and laundry. R1's resident record included an IAPP which contained: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults, abuse includes self-abuse; and - the person's risk abusing other vulnerable adults. R1's record included an IAPP which lacked: - an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults. On January 16, 2025, at 8:37 a.m., clinical nurse supervisor (CNS)-B did not realize it was missing an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (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:	0 680		

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0 680	Continued From page 5 (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 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. In addition, the licensee failed to and evaluate its missing person policy at least quarterly. 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) and was issued at a widespread scope (when problems are pervasive	0 680		

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0 680	Continued From page 6 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's EP plan consisted of several documents and policies in a red three-ringed binder dated reviewed August 2022. The licensee lacked a customized EP plan to include the following required content: -update annually and must document and date of review; -communication plan that includes contact information for the ombudsman, state licensing, and certification agencies; -must take an all-hazard approach, including EIDs as applicable; -subsistence needs for staff and residents; -procedure for tracking staff and residents; -policies and procedures for sheltering; -policies and procedures for medical documents; -policies and procedures for volunteers; and -roles under a waiver declared by secretary. On January 15, 2025, at 9:41 a.m. licensed assisted living director/owner (LALD/O)-A stated they had oversight of the EP Plan and verified the EP plan lacked the contact information as noted above. In addition, LALD/O-A stated the EP plan and policy was last reviewed August 2022. The licensee's undated, Administrative-Plan for Natural Disasters and Emergencies policy read the plan would be updated regularly and the agency would have a written plan of action to facilitate the licensee's resident care and services in a response to a natural disaster or another type of emergency that may affect the ability to provide	0 680		

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0 680	Continued From page 7 services. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service	0 730		

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0 730	Continued From page 8 providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 730		

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0 730	Continued From page 9 licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked a discharge summary to include: -name, address, and telephone number of resident's emergency contact, legal representative, and designated representative; -health information, including medical history, provider managing medications, treatments or therapies that require documentation, and other relevant health records; -copies of any health care directives, guardianships, power of attorney, or conservatorship; -current and previous assessments and service plan; -documentation of significant changes in the resident's status and actions taken; -documentation of incidents; - course of illnesses; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional	0 730		

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0 730	Continued From page 10 status. R2 was admitted to the licensee on July 23, 2024, with diagnoses including left sided weakness, and anemia. R2 discharged from the licensee on September 12, 2024. On January16, 2025, at 8:41 a.m., clinical nurse supervisor (CNS)-B stated they use summary for all discharges and did not realize they were missing the required criteria. Licensed assisted living director/owner (LALD/O)-A stated she was able to view how to correct in their computer software to include all required components. The licensee's undated, Discharge/Transfer Summary policy indicated the registered nurse, LALD, or designee would develop the discharge summary to include all elements. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is	0 780		

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0 780	Continued From page 11 required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 15, 2025, from 10:30 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. The surveyor asked LALD/O-A to initiate a test of the smoke alarms throughout the home. Upon	0 780		

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0 780	Continued From page 12 testing, it was found that the smoke alarms in the facility were not all interconnected. The smoke alarms in resident rooms 4, 5, 6 and the smoke alarm in the hallway outside resident rooms 1, 2, and 3 were not interconnected with the rest of the facility. These deficient conditions were visually verified by LALD/O-A at the time of discovery. On January 15, 2025, at 12:30 p.m., LALD/O-A stated they relocated a few of the smoke alarms since their last survey, but they did not know why the above-listed locations were not interconnected with the rest. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 790		

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	31437	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY PLACE LLC	902 15TH STREET NE SAUK RAPIDS, MN 56379

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0 790	Continued From page 13 failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 15, 2025, from 10:30 a.m. to 11:30 a.m., the surveyor toured the facility with licensed assisted living director/owner (LALD/O)-A. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. On January 15, 2025, at 12:30 p.m., LALD/O-A stated they did not know monthly inspections were required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=D	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;	0 810		

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0 810	Continued From page 14 (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. (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 the required content and to provide the required training and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 810		

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0 810	Continued From page 15 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 15, 2025, licensed assisted living director/owner (LALD/O)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "A: Fire on the Premises" and "C. Evacuations", dated Rev. 2022, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. On January 15, 2025, at 12:30 p.m., LALD/O-A stated they only had one resident that they considered able to assist in their own evacuation and did not realize a section in their policy for resident actions was required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950		

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0 950	Continued From page 16 must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 950		

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0 950	Continued From page 17 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's assisted Living Contract was signed by R1 on May 31, 2024. R1's assisted living contract failed to include statute statement from 144.50 subd. 3 with required verbatim right to designate a representative. On January 14, 2025, licensed assisted living director/owner (LALD/O)-A stated she did not understand that it had to be verbatim per 144.50 subd. 3 when she updated the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01360 SS=D	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of	01360		

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01360	Continued From page 18 unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide training and competency evaluations by a registered nurse (RN) to one of one unlicensed personnel ((ULP)-C) providing assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: ULP-C began employment on April 14, 2021. On January 14, 2025, at 8:19 a.m., the surveyor observed ULP-C administer medications to R1. ULP-C's employee record lacked the following: - documentation requirements for all services provided; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting; - standby assistance techniques and how to	01360		

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01360	Continued From page 19 perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and - awareness of confidentiality and privacy. On January 16, 2025, at 8:52 a.m., clinical nurse supervisor (CNS)-B stated CNS-B utilized the annual check list for licensee's ULP competency training and did not realize the missing elements. The licensee's undated General Orientation Checklist for New employees policy indicated all required training to be completed and documented on verified competencies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01360		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment;	01370		

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01370	Continued From page 20 (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one employee (unlicensed personnel (ULP)-C) to include all required content. 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	01370		

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01370	Continued From page 21 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: ULP-C began employment on April 14, 2021. On January 14, 2025, at 8:19 a.m., the surveyor observed ULP-C administer medications to R1. ULP-D's employee record lacked evidence of training for the following topics: -observing, reporting, and documenting resident status; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - range of motioning and positioning; and - understanding appropriate boundaries between staff and residents and the resident's family. Demonstration of Competency: - appropriate and safe techniques in personal hygiene and grooming; - hair care and bathing including; - care of teeth, gums, and oral prosthetic devices - care and use of hearing aids - dressing and assisting with toileting, and; - standby assistance techniques and how to perform them. On January 16, 2025, at 8:52 a.m., clinical nurse supervisor (CNS)-B stated CNS-B utilized the annual check list for licensee's ULP competency	01370		

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01370	Continued From page 22 training and did not realize the missing elements. The licensee's undated General Orientation Checklist for New employees policy indicated all required training to be completed and documented on verified competencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440		

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01440	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of one unlicensed personnel (ULP-C). 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: ULP-C was hired on April 4, 2021, to provide direct care and services to the facility's residents. On January 14, 2025, at 8:09 a.m., surveyor observed ULP-C administer R1's nebulizer treatment. On January 16, 2025, at 8:51 a.m., licensed assisted living director/owner (LALD/O)-A and clinical nurse supervisor (CNS)-B stated ULP-C's employee record lacked evidence of a 30-day supervision of a delegated task by the RN. The licensee's undated, Supervision Of Licensed and Unlicensed Personnel policy read direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within	01440		

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01440	Continued From page 24 30 days after the person begins work. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
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 label a time sensitive medication with an opened date or included a proper label for two of eight residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings included: MEDICATION OPEN DATE	01890		

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01890	Continued From page 25 R3 R3's started services on August 14, 2023, with licensee. R3's Medication Current as of January 13, 2025, for carboxymethylcell 0.5% eye drops indicated instill one drop into both eyes every 4 hours as needed. On January13, 2025, at 10:47 a.m., the surveyor and clinical nurse supervisor (CNS)-B reviewed the contents of the facility's locked medication cart. R3's open eye drops indicated an open date of October 15, 2024. CNS-B stated her expectation would be to have staff report to CNS-B the eye drop had expired. MEDICATION LABELS R3 R3's started services on August 14, 2023, with licensee. R3's Medication Current as of January 13, 2025, Breo Ellipta 200-25 microgram (mcg)indicated on puff by mouth once daily. On January13, 2025, at 10:47 a.m., the surveyor and CNS-B reviewed the contents of the facility's locked medication cart. R3's open inhaler observed to have no label. CNS-B stated, "I know I placed a name on it and I don't know why it is not on there." R4 R4's Service Plan dated December 15, 2024, indicated she received medication administration. R4's Medication Current as of January 13, 2025, oxycodone 5 milligrams(mg) one tablet my mouth	01890		

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01890	Continued From page 26 every 4 hours as needed for pain. On January13, 2025, at 10:47 a.m., the surveyor and CNS-B reviewed the contents of the facility's locked medication cart. Surveyor observed in the locked narcotic box R4's medication bottle to lack a label with all required elements. CNS-B stated they were aware of the medication in the bottle and there should be a label on the bottle. CNS-B stated she was unsure why there was no label on R4's medication bottle. The licensee's Medication Administration by Unlicensed Staff dated January 3, 2025, indicated administration of medication to ensure compliance with state regulations, patient safety and high-quality care. 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.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31437	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY PLACE LLC	902 15TH STREET NE SAUK RAPIDS, MN 56379

(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
01910	Continued From page 27 (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 disposition of the medication including the prescription numbers as applicable, for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Discharged resident roster dated January 13, 2025, indicated R2 discharged on September 12, 2024, to another facility. R2's discharge summary lacked documentation to have included a record of medication disposition. On January 16, 2025, at 8:41 a.m., clinical nurse supervisor (CNS)-B verified R2's record lacked a medication disposition and was unsure why. Licensed assisted living director/owner	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31437	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY PLACE LLC	902 15TH STREET NE SAUK RAPIDS, MN 56379

(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
01910	Continued From page 28 (LALD/O)-A stated she was able to view within the licensee software program where to document the required elements within the resident's discharge summary that was not performed for R2. The licensee's Disposition or Disposal of Medication policy dated January 2, 2025, identified a resident's current medications that are secured or stored by our facility would be given to the resident or the resident's representative when the resident's medication management services are terminated. The policy identified staff would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. The policy did not direct to include the prescription number as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *01/13/25*
Time: 10:30:32
Report: 1046251010

Food and Beverage Establishment Inspection Report

Location:
Legacy Place Llc
902 15th Street Ne
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:
ID #: 0038120
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202677789
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.

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

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED EGGS STORED ABOVE COLESLAW AND OTHER READY TO EAT ITEMS IN FRIDGE. MOVE TO BOTTOM TO PREVENT CROSS-CONTAMINATION.

Corrected on Site

2-400 Hygenic Practices

2-401.11B

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

OBSERVED OPEN EMPLOYEE BEVERAGES IN THE KITCHEN. DISCONTINUE USING OPEN LIDDED BEVERAGES AND USE CLOSED LIDDED BEVERAGES WHEN IN KITCHEN/PREP AREA.

Comply By: 01/13/25

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: WIPES CONTAINER
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE
Violation Issued: No

Type: Full
Date: *01/13/25*
Time: 10:30:32
Report: 1046251010
Legacy Place Llc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: SOUR CREAM
Violation Issued: No

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

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

DISCUSSED THERMOMETERS IN ALL COOLING UNITS.

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 1046251010 of 01/13/25.

Certified Food Protection Manager Susan M. Norman

Certification Number: 112447 Expires: 08/22/25

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Nicole Larrison
Public Health Sanitarian
St. Cloud
320-472-0042
nicole.larrison@state.mn.us

Report #: 1046251010

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 01/13/25
Time In 10:30:32
Time Out

	Address	City/State	Zip Code	Telephone
Legacy Place Llc	902 15th Street Ne	Sauk Rapids, MN	56379	3202677789

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038120		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		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		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		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:** 01/13/25

Inspector (Signature)