Electronically Delivered

April 16, 2024

Licensee
Caring Nurses LLC - Foxglove
4137 Foxglove Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL34179015

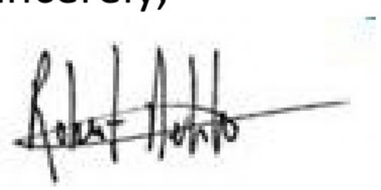
Dear Licensee:

On April 10, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 9, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Robert Dehler, Engineering Manager
Engineering Services Section
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710 Fax: 1-866-890-9290

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Electronically Delivered

January 30, 2024

Licensee
Foxglove
4137 Foxglove Avenue North
Brooklyn Center, MN 55443

RE: Project Number(s) SL34179015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 9, 2024, 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.

**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 . . ."

**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 may be 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.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose 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. 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 (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 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00**

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.

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**

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. 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. to submit a hearing request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Casey DeVries, Supervisor
tate Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34179 | A. BUILDING: _____ B. WING _____ | 01/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FOXGLOVE | 4137 FOXGLOVE AVENUE NORTH BROOKLYN CENTER, MN 55443 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL34179015-0<br><br>On January 8, 2024, through January 9, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents, both received services under the Assisted Living 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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<br><br>(13) offer to provide or make available at least the | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. | 0 510 | | |

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| 0 510 | Continued From page 2<br><br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to shared medical equipment and sharps disposal. This had the potential to affect all residents and staff.<br><br>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).<br><br>The findings include:<br><br>SHARED MEDICAL EQUIPMENT<br>On January 9, 2024, at 8:14 a.m., the surveyor observed unlicensed personnel (ULP)-B obtain vital sign (VS) equipment from inside a kitchen cabinet, walk to R1 in the dining room, place the blood pressure cuff on R1, and obtain R1's blood pressure. ULP-B then returned the blood pressure cuff to the cabinet. The surveyor did not | 0 510 | | |

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| 0 510 | Continued From page 3<br><br>observe ULP-B clean the blood pressure cuff before or after use on R1.<br><br>On January 9, 2024, at 9:08 a.m., ULP-B stated VS equipment should be wiped down after each use. ULP-B stated they forgot to clean the VS equipment because they had a lot going on and were nervous.<br><br>On January 9, 2024, at 9:14 a.m., registered nurse supervisor (RNS)-A stated staff watch videos on infection control. RNS-A stated shared equipment should be wiped down between use.<br><br>The licensee's undated Cleaning and Disinfecting in the Home policy indicated all equipment, environmental, and working surfaces would be cleaned and disinfected after contact with blood or other potentially infectious materials. In addition, all work surfaces would be decontaminated with an appropriate disinfectant after completion of all procedures.<br><br>SHARPS DISPOSAL<br>On January 9, 2024, at 12:26 p.m., the surveyor observed ULP-B perform a blood glucose monitoring on R1. After blood glucose monitoring was complete the surveyor observed ULP-B place sharp and biohazard material under the kitchen counter in an unlocked cabinet, in a clear unlabeled bottle sealed with a yellow top. The surveyor inquired if this is where the licensee disposed sharps. ULP-B stated yes.<br><br>On January 9, 2024, at 12:36 p.m., RNS-A stated the bottle described above was what the licensee used to dispose sharps and biohazard material. RNS-A stated they did not know it was an inappropriate container since it was a hard plastic and sealed by a lid. | 0 510 | | |

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| 0 510 | Continued From page 4<br><br>The food and drug administration (FDA) document titled Sharps Disposal Containers in Health Care Facilities dated April 29, 2021, recommended health care facilities use FDA-cleared sharps disposal containers for disposal of used needles and other sharps.<br><br>The licensee's undated Cleaning and Disinfecting in the Home policy indicated contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:<br>-closable<br>-puncture-resistant<br>-leakproof on sides and bottom<br>-labeled and color-coded.<br>In addition, disposal of all regulated waste shall be in accordance with applicable regulations of the United States, states, and political subdivisions of the states.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 650 SS=E | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency | 0 650 | | |

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| 0 650 | Continued From page 5<br><br>evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of three employees (registered nurse supervisor (RNS)-A, unlicensed personnel (ULP)-B).<br><br>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).<br><br>The findings include:<br><br>RNS-A<br>RNS-A was hired on November 28, 2023, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. | 0 650 | | |

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| 0 650 | Continued From page 6<br><br>RNS-A's employee record lacked the following:<br>-current position description.<br><br>On January 9, 2024, at 11:35 a.m., RNS-A stated they received a position description with their job offer letter.<br><br>ULP-B<br>ULP-B was hired on September 15, 2015, to provide direct care to residents.<br><br>On January 9, 2024, at 12:26 p.m., the surveyor observed ULP-B perform blood glucose monitoring on R1.<br><br>ULP-B's employee record included a performance review dated May 31, 2021, however lacked further performance reviews that identified areas of improvement needed and trainings needed. In addition, ULP-B's employee record lacked the following:<br>- record of 30-day supervision; and<br>- competency evaluations to include the following treatments or therapies:<br>- blood glucose monitoring; and<br>- continuous positive airway pressure (CPAP).<br><br>On January 9, 2024, at 11:22 a.m., ULP-B stated they received training and a competency evaluation related to the CPAP therapy and blood glucose monitoring by a registered nurse (RN). In addition, ULP-B stated, "it (documentation) should be at the office."<br><br>On January 9, 2024, at 1:39 p.m., RNS-A stated all new employees receive an online packet from EduCare (a training software) to complete for orientation and once the packet was completed | 0 650 | | |

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| 0 650 | Continued From page 7<br><br>the ULP attended a training session in person at the licensee's training room. RNS-A stated ULP would then complete all required competency evaluations with a RN and within 30 days of the competency evaluations being completed the RN would complete a 30-day supervision with the ULP. In addition, RNS-A stated they were unaware of why ULP-B's competency evaluations and 30-day supervisions were not located in the employee file.<br><br>On January 9, at 2:05 p.m., housing manager (HM)-C stated they did not have any further employee records for ULP-B.<br><br>The licensee's undated Employee Records policy read, "1. Employee records must include the following information:<br>a. Evidence of current professional licensure, registration, or certification if licensure, registration or certification is required<br>b. Records of orientation, required annual training, infection control training and competency evaluations<br>c. Current signed job descriptions, including qualifications, responsibilities and identification of staff persons providing supervision<br>d. Documentation of annual performance reviews that identify areas of improvement needed and training needs<br>e. For individuals providing assisted living services, verification that required health screenings under Subd. 9 (TB prevention and control) have taken place and the dates of those screenings; and<br>f. Documentation of the background study as required under section 144.057."<br><br>No further information provided. | 0 650 | | |

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| 0 650 | Continued From page 8<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an updated facility TB risk assessment and a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of three employees (registered nurse supervisor (RNS)-A). This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 660 | | |

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| 0 660 | Continued From page 9<br><br>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).<br><br>The findings include:<br><br>RISK ASSESSMENT<br>The facility TB risk assessment was completed May 31, 2022, and indicated the facility was at a medium risk for TB transmission and the licensee would conduct or update the TB risk assessment annually. The licensee lacked an updated TB risk assessment.<br><br>On January 9, 2024, at 1:44 p.m., registered nurse supervisor (RNS)-A stated they did not know how often the TB facility risk assessment should be conducted or updated. Housing manager (HM)-C stated it should be conducted yearly. RNS-A and HM-C both stated they were unaware of why the TB facility risk assessment was not updated.<br><br>The Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Settings Licensed by MDH dated June 2023 indicated facilities should perform a facility risk assessment on an annual basis.<br><br>The licensee's undated Tuberculosis Prevention and Control policy read, "Facility will complete the Community TB Risk Assessments annually."<br><br>TB SCREENING<br>RNS-A was hired on November 28, 2023, to provide supervision and oversite to unlicensed | 0 660 | | |

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| 0 660 | Continued From page 10<br><br>personnel and to provide direct services to residents.<br><br>RNS-A's employee record included one tuberculin skin test (TST) completed on November 27, 2023, however lacked a tuberculosis (TB) screening to include a second step TST tuberculin skin test or other evidence of a TB screening such as a blood test.<br><br>RNS-A stated the clinical nurse supervisor (CNS) of the facility completed a two-step TST and evidence of it should be located in their employee file but was unable to produce it for the surveyor. The licensee's CNS was unavailale for interview.<br><br>The CDC's document titled TB Screening and Testing of Health Care Personnel dated August 20, 2022, indicated a TST was used to test health care personnel for TB upon hire, and two-step testing should be used.<br><br>The licensee's undated Tuberculosis Screening policy indicated each employee who had direct contact with residents must have documentation of a baseline health symptom screening prior to providing care to residents. This would include at minimum a health symptom screening, and a TB skin testing via the Mantoux method.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following | 0 680 | | |

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| 0 680 | Continued From page 11<br><br>requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.<br><br>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 | 0 680 | | |

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| 0 680 | Continued From page 12<br><br>failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On January 8, 2024, at 11:05 a.m., housing manger (HM)-C provided the licensee's EPP. The surveyor observed the document and noted the following sections were left blank and not filled in by the licensee with facility specific information:<br>- staffing shortages, staffing surges, and back-up plans;<br>- staffing plan for sheltering in place;<br>- use of volunteers when sheltering in place;<br>- methods of sharing information about a resident in an emergency;<br>- describe the facility's role in providing care and treatment at alternate care sites under the 1135 wavier; and<br>- use of volunteers if evacuation needed.<br><br>The licensee's emergency disaster preparedness plan lacked evidence of the following required content:<br>- develop an EP which included emerging infectious diseases;<br>- develop strategies for addressing facility and community based risks which included staffing shortages, staffing surges, and back-up plans;<br>- policy and procedures for staff and volunteers who remained in the facility while sheltering in place;<br>- strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans;<br>- copies of arrangements agreements with other facilities;<br>- roles under a wavier declared by secretary;<br>- name and contact information;<br>- emergency officials contact information; | 0 680 | | |

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| 0 680 | Continued From page 13<br>- methods for sharing information; and<br>- emergency prep testing requirements.<br><br>On January 9, 2024, at 2:18 p.m., registered nurse supervisor (RNS)-A stated they were unaware why certain areas on the EPP were not filled in with the licensee specific information. In addition, RNS-A stated if an evacuation was needed, the licensee's residents and staff members would evacuate to a local hotel.<br><br>The licensee's undated Emergency Management Policy indicated the licensee would have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 700 SS=F | 144G.43 Subdivision 1 Resident record<br><br>(b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure personal | 0 700 | | |

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| 0 700 | Continued From page 14<br><br>health and medical information was kept private for two of two residents (R1, R2).<br><br>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).<br><br>These finding include:<br><br>On January 8, 2024, 9:45 a.m., the surveyor observed a closet with no door lock, on the main floor next to the main entrance. In the closet, the surveyor observed a total of five white document boxes which included two boxes marked with R1's name, two boxes marked with R2's name, and one box marked daily paperwork for R1 and R2. The boxes contained medical information for R1 and R2. The surveyor observed there was no physical means to lock or secure the door to keep medical information private.<br><br>On January 8, 2024, 9:58 a.m., registered nurse supervisor (RNS)-A stated they were unaware the door had to be secured. Housing manager (HM)-C stated they would reach out to maintenance and have them place a lock on the door.<br><br>On January 8, 2024, 10:28 a.m., surveyor observed sub-contractor (SC)-E place a door lock onto the closet door that contained the medical information of R1 and R2.<br><br>No further information provided. | 0 700 | | |

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| 0 700 | Continued From page 15<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 700 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is 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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so the actuation of one alarm causes all alarms in the dwelling unit to | 0 780 | | |

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| 0 780 | Continued From page 16<br><br>actuate. This deficient condition had the ability to affect all staff and residents.<br><br>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).<br><br>The findings include:<br><br>On January 9, 2024, at 10:30 a.m., survey staff toured the facility with facilities manager (FM)-F. Survey staff tested the smoke alarms throughout the home. Upon testing, it was found the smoke alarms in the following locations did not sound when the test button was pressed:<br><br>1. Bedroom #1 had no smoke alarm installed.<br>2. The lower level had no smoke alarms installed.<br><br>These deficient conditions were verified by FM-F accompanying on the tour.<br><br>During interview on January 9, 2024, at 10:30 a.m, FM-F stated they had installed all new smoke alarms, but she did not know why the above-listed locations were missing their smoke alarms. Survey staff told her the lower level must have at least one smoke alarm but recommended installing smoke alarms in all the spaces required by statute for the planned future bedroom expansion.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780 | | |

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| 0 830 SS=D | 144G.45 Subd. 3 Local laws apply<br><br>Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, record review and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>The findings include:<br><br>On January 9, 2024, at 10:30 a.m., survey staff toured the facility with facilities manager (FM)-F. It was observed the lower level of the home was under construction and the construction had not been completed.<br><br>During interview on January 9, 2024, at 10:30 a.m., , FM-F stated the lower level was not being used because it was not legally built. She stated the previous owner had hired a contractor to add bedrooms and living spaces to the lower level, | 0 830 | | |

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| 0 830 | Continued From page 18<br><br>but the contractor failed to complete the required inspections from the city so there was never a certificate of occupancy issued for the work. FM-F stated she was working with the owner to complete the work and get the final certificate of occupancy, but it was a slow process due to legal issues with the original contractor. Survey staff explained to FM-F no residents should be moved in until the construction is complete and the city has issued a certificate of occupancy. FM-F stated she understood no residents could occupy the lower level and stated there were no plans to move anyone into that space until it was finished.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 830 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement | 01060 | | |

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| 01060 | Continued From page 19<br><br>that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for a resident's emergency relocation to the resident, legal representative, or designated representative, for one of one resident (R2).<br><br>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 | 01060 | | |

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| 01060 | Continued From page 20<br>a large portion or all of the residents).<br><br>The findings include:<br><br>R2 admitted to the licensee on August 31, 2021, and began receiving assisted living services.<br><br>R2's Service Plan (Wavier)- Addendum to Contract signed March 23, 2023, indicated R2 received assistance with bathing reminders, continuous positive airway pressure (CPAP) therapy, medication administration, nail care, blood glucose daily, skin care, and skin treatment one day per week.<br><br>R2's Hospitalization Record indicated R2 was hospitalized on December 11, 2023, at 7:18 a.m., through December 13, 2023, at 1 :00 p.m.<br><br>R2's medical record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice.<br><br>On January 9, 2024, at 8:11 a.m., registered nurse supervisor (RNS)-A and HM-C both stated they were not aware of the requirement, and they had not provided an emergency relocation notice for any hospitalized residents.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01060 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter; | 01470 | | |

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| 01470 | Continued From page 21<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss | 01470 | | |

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| 01470 | Continued From page 22<br><br>and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of three employees (unlicensed personnel (ULP)-B).<br><br>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).<br><br>The findings include:<br><br>ULP-B was hired on September 15, 2015, to provide direct care to residents.<br><br>On January 9, 2024, at 7:18 a.m., the surveyor observed ULP-B administer oral and topical medication to R2. | 01470 | | |

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| 01470 | Continued From page 23<br><br>On January 9, 2024, at 12:26 p.m., the surveyor observed ULP-B perform blood glucose monitoring on R1.<br><br>ULP-B's employee record included training on home care orientation completed May 15, 2015, and March 28, 2018. In addition, ULP-B's employee record included an EduCare (a training software) transcript which indicated assisted living bill of rights was assigned to ULP-B on March 22, 2023, however ULP-B did not complete the course. ULP-B's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following:<br>- an overview of this assisted living statutes;<br>- assisted living bill of rights; and<br>- a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br><br>On January 9, 2024, at 11:22 a.m., ULP-B stated they received orientation in person and by EduCare when they were hired. The surveyor inquired if they received additional orientation when the licensee converted from a comprehensive license to an assisted living license. ULP-B stated they were unable to recall if they received training on the topics listed above.<br><br>On January 9, 2024, at 1:39 p.m., registered nurse supervisor (RNS)-A stated all new staff receive an online packet from EduCare to complete for orientation and once the packet was completed the ULP attends a training session in person at the licensee's training room.<br><br>On January 9, at 2:05 p.m., housing manager | 01470 | | |

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| 01470 | Continued From page 24<br><br>(HM)-C stated they did not have any further employee records for ULP-B.<br><br>The licensee's undated Qualifications, Training, and Competency policy indicated the licensee shall provide training to all staff providing and supervising assisted living services at the time of hire, and as needed to meet state guideline and quality standards.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01500 SS=D | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; | 01500 | | |

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| 01500 | Continued From page 25<br><br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of two employees | 01500 | | |

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| 01500 | Continued From page 26<br>(ULP-B).<br><br>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).<br><br>The findings include:<br><br>ULP-B was hired on September 15, 2015, to provide direct care to residents.<br><br>ULP-B's employee record included a EduCare (a training software) transcript dated January 9, 2024, with multiple classes assigned for ULP-B to complete in 2023, however ULP-B did not start the assigned classes. ULP-B's employee record lacked eight hours of annual training completed within the last 12 months for 2022 and 2023 to include:<br>- reporting maltreatment of vulnerable adults;<br>- infection control;<br>- assisted living bill of rights;<br>- review of provider policies and procedures;<br>- principles of person-centered planning/service delivery; and<br>- dementia training (two hours required).<br><br>On January 9, 2024, ULP-B stated the licensee completes training yearly on EduCare. In addition, ULP-B stated they believed they completed EduCare classes in October or November of this year.<br><br>On January 9, 2024, at 11:44 a.m., registered | 01500 | | |

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| 01500 | Continued From page 27<br><br>nurse supervisor (RNS)-A stated employees received eight hours of annual training on Educare. In addition, RNS-A stated if an employee had additional training needs, they would provide it.<br><br>On January 9, at 2:05 p.m., housing manager (HM)-C stated they did not have any further employee records for ULP-B.<br><br>The licensee's undated Annual Training Requirements policy indicated all staff that provided direct care services in the assisted living must complete at least eight hours of annual training for each 12 months of employment.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01500 | | |
| 01530 SS=D | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another | 01530 | | |

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| 01530 | Continued From page 28<br><br>employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date for one of three employees (unlicensed personnel (ULP)-B).<br><br>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).<br><br>The findings include:<br><br>ULP-B was hired on September 11, 2015, to provide direct services to the residents.<br><br>On January 9, 2024, at 7:18 a.m., the surveyor observed ULP-B administer oral and topical medication to R2. | 01530 | | |

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| 01530 | Continued From page 29<br><br>ULP-B's employee record included an EduCare transcript (a training software) which identified .75 hours of dementia care training completed on March 2, 2021, and included 8.25 hours of dementia care training that was assigned to ULP-B however, was not completed. ULP-B's record lacked eight hours of initial dementia care training within the first 160 hours of employment.<br><br>On January 9, 2024, at 11:22 a.m. ULP-B stated they received dementia care training however were unable to recall how many hours they received. In addition, ULP-B stated they received the training on EduCare.<br><br>On January 9, 2024, at 11:44 a.m., registered nurse supervisor (RNS)-A stated all employees received eight hours of dementia care training on Educare. RNS-A was unaware of why ULP-B's employee record did not contain the eight hours of dementia care on the required topics.<br><br>On January 9, at 2:05 p.m., housing manager (HM)-C stated they did not have any further employee records for ULP-B.<br><br>The licensee's undated Dementia Care Training policy indicated direct care employees must have completed at least eight hours of initial training on required topics in the first 160 hours of employment. In addition, until the training was complete the employee must not provide direct care unless there was another employee on site who has completed the eight hours of training related to dementia care and who can act as a resource and assist if issue arise.<br><br>No further information provided. | 01530 | | |

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| 01530 | Continued From page 30<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for one of two residents (R2). | 01640 | | |

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| 01640 | Continued From page 31<br><br>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).<br><br>The findings include:<br><br>R2 admitted to the licensee on August 31, 2021, and began receiving assisted living services.<br><br>R2's diagnoses included diabetes, suicide attempt, asthma, schizoaffective disorder (mental disorder characterized by abnormal thought process and an unstable mood), generalized anxiety disorder, traumatic brain injury (TBI), paranoid schizophrenia (mental disorder characterized by continuous or relapsing episodes of psychosis), psychosis (mental condition in which thought, and emotions are so affected that contact is lost with external reality) and seizure disorder.<br><br>On January 9, 2024, at 7:18 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral and topical medication to R2.<br><br>R2's Service Plan (Wavier)- Addendum to Contract signed March 23, 2023, indicated R2 received assistance with bathing reminders, continuous positive airway pressure (CPAP) therapy, medication administration, nail care, blood glucose daily, skin care, and skin treatment one day per week.<br><br>R2's unsigned Service Plan (Wavier)-Addendum | 01640 | | |

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| 01640 | Continued From page 32<br><br>to Contract effective date of January 9, 2024, indicated R2 received assistance with activities, appointments, bathing reminders, bedmaking, CPAP therapy, housekeeping, dressing in the morning and evening, laundry, behavior management, medical symptom management, meal reminder, medication administration, nail care, vital signs, garbage removal, safety checks, shopping assistance, skin care, and transportation.<br><br>R2's service plans lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred.<br><br>On January 8, 2024, at 2:26 p.m., registered nurse supervisor (RNS)-A stated R2 did not receive blood glucose monitoring.<br><br>On January 9, 2024, at 1:45 p.m., RNS-A stated RTasks (a documenting software program) generated a service plan based on the resident's nursing assessment. RNS-A stated if services were added or removed from the service plan the licensee would obtain a signature from the resident or guardian. In addition, RNS-A stated they were unaware of why R2 did not sign a new service plan when revisions were made. Housing manager (HM)-C stated, "maybe they forgot to have him sign it."<br><br>The licensee's undated Service Plan policy indicated the service plan and any revisions made to the service plan, must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided. | 01640 | | |

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| 01640 | Continued From page 33<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered | 01730 | | |

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| 01730 | Continued From page 34<br><br>as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of two residents (R2).<br><br>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).<br><br>The findings include:<br><br>R2 admitted to the licensee on August 31, 2021, and began receiving assisted living services.<br><br>R2's diagnoses included diabetes, suicide attempt, asthma, schizoaffective disorder (mental disorder characterized by abnormal thought process and an unstable mood), generalized anxiety disorder, traumatic brain injury (TBI), paranoid schizophrenia (mental disorder | 01730 | | |

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| 01730 | Continued From page 35<br><br>characterized by continuous or relapsing episodes of psychosis), psychosis (mental condition in which thought, and emotions are so affected that contact is lost with external reality) and seizure disorder.<br><br>R2's Service Plan (Wavier)- Addendum to Contract signed March 23, 2023, indicated R2 received assistance with bathing reminders, continuous positive airway pressure (CPAP) therapy, medication administration, nail care, blood glucose daily, skin care, and skin treatment one day per week.<br><br>On January 9, 2024, at 7:43 a.m., unlicensed personnel (ULP)-B stated R2 had a rash on the lower back, and they would assist with application of the topical medication because R2 was unable to reach the area to apply the medication. ULP-B and the surveyor entered R2's room. The surveyor observed ULP-B apply ammonium lactate 12 % cream to R2's lower back. The surveyor inquired where the topical cream should be applied. R2 stated cream was to be applied to the lower back, both shoulders, and waistline on the front of their body. ULP-B applied the cream to the shoulder blades and abdomen of R2.<br><br>R2's Med Sheets dated January 1, 2024, through January 31, 2024, included ammonium lactate 12 % cream apply topically twice per day, indications skin treatment, and admin (administration) self. The Med Sheets lacked specific resident instructions related to ammonium lactate on were to apply the topical medication. In addition, the Med Sheets inaccurately reflected R2's ability to apply medicated creams.<br><br>R2's Individualized medication Management Plan dated December 21, 2023, indicated R2 was | 01730 | | |

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| 01730 | Continued From page 36<br><br>unable self-administer medications, the facility caregivers administered all scheduled and as needed medications, and ULP administered ear drops, eye drops, inhaler, nasal, oral, nebulizer, rectal, sublingual, topical, and transdermal medications. In addition, the nurse was responsible for monitoring and reordering medications, medications were stored in a locked cupboard, and ULP were to contact the nurse by phone or text with any medication concerns.<br><br>R2's medication management plan comprised of multiple documents lacked the following:<br>- documentation of specific resident instructions related to the administration of medications.<br><br>On January 9, 2024, at 8:33 a.m., registered nurse supervisor (RNS)-A stated R2 was not safe to self-administer any medications including topical medications. The surveyor inquired where R2's ammonium lactate should be applied. RNS-A stated R2 had a couple of dry areas on the back and the front of body where R2's suspenders caused irritation. RNS-A stated instructions should be located in the ULP binder. RNS-A looked in the ULP binder for instructions, however, was unable to find them. RNS-A stated they were unsure why the instructions were not listed.<br><br>The licensee's undated Individualized Medication Management Plan and Record policy indicated the medication management plan must include documentation of specific resident instructions related to the administration of medications.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |

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| 01820 SS=D | 144G.71 Subd. 13 Prescriptions<br><br>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to maintain current medication orders for one of two residents (R1).<br><br>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).<br><br>The findings include:<br><br>R1's diagnosis included chronic kidney disease - stage 4, hyperparathyroidism (over active parathyroid), end stage renal disease (ESRD/kidney failure), schizo-affective disorder - bipolar type one (hallucinations or delusions, as well as symptoms of a mood disorder), diabetes mellitus type two (DM2) with diabetic nephropathy (diabetic induced kidney failure), hypothyroidism (under active thyroid), obsessive compulsive disorder (OCD), generalized anxiety disorder (GAD), history of hoarding, dependent personality disorder (type of anxious personality disorder. People often feel helpless, submissive and incapable of taking care of themselves). | 01820 | | |

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| 01820 | Continued From page 38<br><br>R1 Service Plan (Waiver) Addendum to Contract signed on August 14, 2023, indicated R1 received assistance with activities, appointments, bathing reminders, continuous positive airway pressure (CPAP) therapy, dressing, grooming, housekeeping, meals, laundry, medication administration, blood glucose monitoring, nail care, vital sign monitoring, shopping assistance, skin care, and transportation.<br><br>R1's signed provider orders dated June 8, 2023, indicated R1 was prescribed the following medications: aspirin enteric coated (EC) 81 milligrams (mg) calcitriol 0.5 micrograms (mcg), clopidogrel 75 mg, clozapine 100 mg, divalproex 500 mg extended release (ER), ferrous sulfate 325 mg, glipizide 5 mg ER, hydroxyzine hydrochloride 25 mg, isosorbide mononitrate 30 mg ER, levothyroxine 50 mcg, magnesium oxide 400 mg, melatonin 3 mg, metoprolol 25 mg ER, psyllium fiber 0.52 grams (g), tab-a-vitamin, vitamin D3 1,000 unit (U). In addition, the provider orders indicated R1 was prescribed the following medications as needed: Alcohol prep pad, arthritis pain 650 mg, hydrochloride 25 mg, nitroglycerin 0.4 mg.<br><br>R1's medication administration record (MAR) dated January 1, 2024, through January 31, 2024, indicated R1 received the following medications: levothyroxine 50 mcg, calcitriol 0.5 mcg, clopidogrel 75 milligrams mg, clozapine 100 mg, glipizide 5 mg ER, isosorbide mononitrate 30 mg ER, metoprolol 25 mg ER, psyllium fiber 0.52 g, sertraline 100 mg, ferrous sulfate 325 mg, tab-a-vitamin, vitamin D3 1,000 U, divalproex 500 mg ER, hydroxyzine hydrochloride (HCL) 25 mg, melatonin 3 mg, rosuvastatin 20 mg. R1's MAR did not include the following prescribed | 01820 | | |

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| 01820 | Continued From page 39<br><br>medications: nitroglycerin 0.4 mg and arthritis pain 650 mg.<br><br>On January 9, 2024, at 1:07 p.m., registered nurse supervisor (RNS)-A stated they were not able to produce documentation from R1's medical record to show nitroglycerin 0.4 mg and arthritis pain 650 mg had been discontinued for R1. RNS-A stated the licensee's documentation system had multiple resident orders that were unlabeled and unorganized, and they were unable to locate the two orders listed above for R1.<br><br>The licensee's undated policy Medication Prescription and Refills policy indicated upon receiving verbal orders, the registered nurse (RN) or licensed practical nurse (LPN) will record and sign verbal orders and forward the order to the prescriber for signature.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01820 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to store all prescription medications securely to permit only authorized personnel to have access for two of two residents | 01880 | | |

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| 01880 | Continued From page 40<br>(R1, R2).<br><br>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).<br><br>The findings include:<br><br>R1<br>R1 Service Plan (Waiver) Addendum to Contract signed on August 14, 2023, indicated R1 received assistance with activities, appointments, bathing reminders, continuous positive airway pressure (CPAP) therapy, dressing, grooming, housekeeping, meals, laundry, medication administration, blood glucose monitoring, nail care, vital sign monitoring, shopping assistance, skin care, and transportation.<br><br>R1 medications include levothyroxine 50 micrograms (mcg), calcitriol 0.5 mcg, clopidogrel 75 milligrams (mg), clozapine 100 mg, glipizide 5 mg extended release (ER), isosorbide mononitrate 30 mg ER, metoprolol 25 mg ER, psyllium fiber 0.52 grams (g), sertraline 100 mg, ferrous sulfate 325 mg, tab-a-vitamin, vitamin D3 1,000 unit (U), divalproex 500 mg ER, hydroxyzine hydrochloride (HCL) 25 mg, melatonin 3 mg, rosuvastatin 20 mg.<br><br>On January 9, 2024, 8:14 a.m., the surveyor observed unlicensed personnel (ULP)-B unlock the medication cabinet, remove a container containing all medications and two documenting | 01880 | | |

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| 01880 | Continued From page 41<br><br>binders for R1, and place the items onto the kitchen counter. ULP-B administered oral medication to R1, R1 returned to their assigned room located down the hall from the kitchen area, and ULP-B returned to the kitchen to complete paperwork. ULP-B then exited the kitchen with the medications left on the kitchen island and entered R1's room. The surveyor observed subcontractor (SC)-E servicing the kitchen faucet located next to the kitchen island. ULP-B re-entered the kitchen two minutes after exiting the kitchen. ULP-B was observed to leave R1's medication which included two medication cards, one blister packet, and one pill bottle on the kitchen island, unsecured and unsupervised.<br><br>On January 9, 2024, at approximately 8:30 a.m., SC-E stated they were not an employee of the licensee and were subcontracted to complete maintenance tasks at the facility.<br><br>On January 9, 2024, at 8:57 a.m., ULP-B stated medications should be secured when not in use.<br><br>R2<br><br>R2's Service Plan (Wavier)- Addendum to Contract signed March 23, 2023, indicated R2 received assistance with bathing reminders, continuous positive airway pressure (CPAP) therapy, medication administration, nail care, blood glucose daily, skin care, and skin treatment one day per week.<br><br>R2's Individualized medication Management Plan dated December 21, 2023, indicated R2 was unable self -administer medications.<br><br>On January 9, 2024, at 7:18 a.m., ULP-B stated R2's ammonium lactate 12 percent (%) cream | 01880 | | |

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| 01880 | Continued From page 42<br>was in R2's room.<br><br>On January 9, 2024, 2024, at 7:43 a.m., the surveyor observed R2's ammonium lactate 12 % cream on R2's bedside table.<br><br>On January 9, 2024, at 8:33 a.m., registered nurse supervisor (RNS)-A stated they do not keep any medications in resident rooms and medications were locked in the medication cabinets. RNS-A stated and if a topical medication was needed, it would need to be squeezed into a medication cup and brought to the resident room. In addition, RNS-A stated R2 was not safe to self-administer any medications including topical medications.<br><br>The licensee's undated Medication Set Up policy indicated all medication should be stored in the facility in a safe and secure location which is out of sight from visitors to the facility.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must | 01940 | | |

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| 01940 | Continued From page 43<br><br>contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R1).<br><br>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). | 01940 | | |

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| 01940 | Continued From page 44<br>The findings include:<br><br>R1 admitted to the licensee on August 16, 2019, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.<br><br>R1 Service Plan (Waiver) Addendum to Contract signed on August 14, 2023, indicated R1 received assistance with activities, appointments, bathing reminders, continuous positive airway pressure (CPAP) therapy, dressing, grooming, housekeeping, meals, laundry, medication administration, blood glucose monitoring, nail care, vital sign monitoring, shopping assistance, skin care, and transportation.<br><br>On January 8, 2024, at approximately 9:50 a.m., during facility tour, the surveyor observed a CPAP machine on R1's nightstand.<br><br>R1's signed provider orders dated June 8, 2023, included clean CPAP with warm water, v-oil, soak for one hour once a month document refusal, CPAP on in the evening off in the morning, and clean CPAP with warm water and soak for one hour once a day.<br><br>R1's Individualized Treatment and Therapy Plan dated January 8, 2024, lacked information related to the CPAP.<br><br>R1's treatment administration record (TAR) dated January 1, 2024, through January 31, 2024, included the following order, "CLEAN CPAP WITH WARM WATER AND SOAK FOR ONE HOUR ONCE A DAY IN THE EVENING. DOCUMENT REFUSAL" and "CLEAN CPAP WITH WARM WATER, V-OIL, SOAK FOR 1 HOUR ONCE A MONTH. DOCUMENT | 01940 | | |

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| 01940 | Continued From page 45<br>REFUSAL"<br><br>R1's individualized treatment management plan comprised of multiple records lacked the following required content:<br>- procedures to notify a registered nurse (RN) or other licensed health professional when problems arose with treatment or therapies.<br><br>On January 9, 2024, at 11:22 a.m., registered nurse supervisor (RNS)-A stated they did not put this information into their assessment but believed it could be found in the ULP documentation binders. RNS-A attempted to locate the information. RNS-A stated they were unable to find the information listed above and they were aware of the requirement for medication management plans but not for the treatment and therapy management plans.<br><br>The licensee's undated Treatment and Therapy Management Plan policy indicated the individualized treatment or therapy plan would include procedures for notifying a registered nurse or other licensed health professional if problems arise with the treatment tor therapy services.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 01970 SS=D | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a | 01970 | | |

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| 01970 | Continued From page 46<br><br>description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded prescriber's orders were maintained for one of two residents (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2 admitted to the licensee on August 31, 2021, and began receiving assisted living services.<br><br>R2's diagnoses included diabetes.<br><br>R2's Service Plan (Wavier)- Addendum to Contract signed March 23, 2023, indicated R2 received assistance with bathing reminders, continuous positive airway pressure (CPAP) therapy, medication administration, nail care, blood glucose daily, skin care, and skin treatment one day per week.<br><br>R2's unsigned Service Plan (Wavier)-Addendum to Contract effective date of January 9, 2024, indicated R2 received assistance with activities, | 01970 | | |

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|---|---|---|---|---|
| 01970 | Continued From page 47<br><br>appointments, bathing reminders, bedmaking, CPAP therapy, housekeeping, dressing in the morning and evening, laundry, behavior management, medical symptom management, meal reminder, medication administration, nail care, vital signs, garbage removal, safety checks, shopping assistance, skin care, and transportation.<br><br>R2's treatment administration record (TAR) dated January 1, 2024, through January 31, 2024, included the following orders, "TED (COMPRESSION) STOCKINGS AS TOLERATED FYI" and "BLOOD SUGAR CHECKS TO BE DONE AS NEEDED (PRN) PRN". Both orders had not been administered by the licensee's staff in the month of January.<br><br>On January 8, 2024, at 2:26 p.m., the surveyor requested R2's provider orders for the treatments listed above. Registered nurse supervisor (RNS)-A stated R2 did not receive blood glucose monitoring and they would look for the documentation of discontinuation. In addition, RNS-A stated R2's compression stockings were discontinued, and they would look for the discontinuation order in the system.<br><br>On January 9, 2024, at 8:07 a.m., RNS-A stated they contacted the director of nursing (DON) related to the orders above and did not receive a response yet.<br><br>On January 9, 2024, at 12:00 a.m., RNS-A stated the licensee did not have record of the discontinuation of the two treatments or a current provider order for the two treatments. RNS-A stated the DON contacted the primary provider and they did not have record of R2 being started on the two treatments. RNS-A stated they believe | 01970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34179 | A. BUILDING: _____ B. WING _____ | 01/09/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FOXGLOVE | 4137 FOXGLOVE AVENUE NORTH BROOKLYN CENTER, MN 55443 |

| (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 |
|---|---|---|---|---|
| 01970 | Continued From page 48<br><br>the orders came from the hospital and when R2 returned to the facility the orders were discontinued shortly after readmission. In addition, RNS-A stated they believed the orders should have been discontinued from the TAR and the TAR was not updated with the information.<br><br>The licensee's undated Treatment and Therapy Management Plan policy indicated when the nurse or therapist received a verbal order from a provider they shall immediately record and sign the telephone order and obtain the providers countersignatures. In addition, a system will be used by the licensee to ensure telephone orders are signed and dated by the provider and returned to the resident's clinical record and all providers orders shall be maintained in the clinical record.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01970 | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/08/24*
Time: 11:15:00
Report: 1039241010

# Food and Beverage Establishment Inspection Report



**Location:**
Foxglove
4137 Foxglove Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

**Establishment Info:**
ID #: 0037679
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7635664325
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.

SHELL EGGS STORED ABOVE PRODUCE AND OTHER READY-TO-EAT FOODS IN REFRIGERATOR. GAVE GUIDANCE ON STACKING TO PREVENT CROSS-CONTAMINATION. PERSON-IN-CHARGED MOVED EGGS TO DRAWER IN REFRIGERATOR.

*Corrected on Site*

**3-500B Microbial Control: hot and cold holding**

***3-501.16A2*** ***** Priority 1 *****

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

AMBIENT REFRIGERATOR TEMPERATURE MEASURES 44 DEGREES F. REFRIGERATOR CONTAINS SHELL EGGS. COMPLY WITH ABOVE.

*Comply By: 01/08/24*

**2-100 Supervision**

***2-102.12AMN***

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

STAFF STATES THEY HAVE COMPLETED AN APPROVED FOOD SAFETY COURSE. REGISTER WITH MDH TO OBTAIN CFPM CERTIFICATE. GUIDANCE DOCUMENT ON THE CFPM PROGRAM SENT WITH REPORT.

*Comply By: 02/05/24*

Type: Full
Date: *01/08/24*
Time: 11:15:00
Report: 1039241010
Foxglove

# Food and Beverage Establishment Inspection Report

**4-500 Equipment Maintenance and Operation**

***4-501.11AB***

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

REFRIGERATOR AMBIENT TEMPERATURE MEASURES 44 DEGREES F. PERSON-IN-CHARGE ADJUSTED THERMOSTAT TO LOWER REFRIGERATOR TEMPERATURE. PERSON-IN-CHARGE WILL MEASURE REFRIGERATOR AFTER EQUILIBRATION TO INSURE FOODS CAN BE HELD AT 41 DEGREES F OR BELOW.

*Comply By: 01/09/24*

**Surface and Equipment Sanitizers**

Utensil Surface Temp: = at >150 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Ashley Crews

The kitchen is of residential build and should serve food for same-day service only.

The kitchen has wood cabinets with hollow base, wood floor, painted walls and ceiling and faux-marble countertops

The kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

A 2-compartment sink is present in kitchen. 1 compartment is designated for hand washing only.

A residential dishwashing machine is located in the kitchen. A color change thermo-label sticker was placed in the dishwashing machine by the person-in-charge. The person-in-charge sent a photo of the sticker later in the day showing a utensil surface temperature >150 degrees F. The dishwashing machine should be used to wash all dishes and utensils and with the sanitize setting "ON".

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen.

Sealed cans and sealed containers of food are stored on shelving in garage.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing, all orders on report.

Type: Full
Date: *01/08/24*
Time: 11:15:00
Report: 1039241010
Foxglove

# Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1039241010 of 01/08/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

**Inspection report reviewed with person in charge and emailed.**

Signed:_____

Tanaya Nash
person-in-charge

Signed:_____

Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us