DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 7, 2022

Administrator
Skylight Gardens Apartments, LLC
501 1st Street North
Saint Cloud, MN 56303

RE: Project Number(s) SL20347015

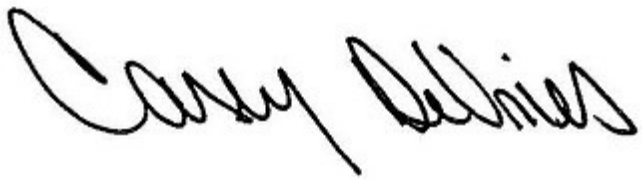
Dear Administrator:

On November 4, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 21, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

PMB

Electronically Delivered

October 10, 2022

Administrator
Skylight Gardens Apartments, LLC
501 1st Street North
Saint Cloud, MN 56303

RE: Project Number(s) SL20347015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 21, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal. **OR** Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20347015-0 On September 19, 2022, through September 21, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 56 residents, 55 receiving services under the provider's Assisted Living license. An immediate correction order was identified on September 19, 2022, and was issued to the licensee on September 20, 2022, issued for SL20347015-0, tag identification 2310. On September 21, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level 3/widespread violation.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared 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 included document titled, Food and Beverage Establishment Inspection Report dated September 19, 2022, for the specific	0 480		

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0 480	Continued From page 2 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 640		

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0 640	Continued From page 3 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility. On September 19, 2022, during the facility tour at approximately 11:59 a.m., the surveyor observed the entry area, common areas, and charting areas within the facility, and noted there was no required posting of the 911 emergency number, as required. On September 21, 2022, at approximately 2:17 p.m. licensed assisted living director (LALD)-B confirmed the 911 emergency information was not posted, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 4 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the initial tour on September 19, 2022, at	0 680		

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0 680	Continued From page 5 approximately 11:59 a.m., the surveyor observed the facility's layout included one large building with three levels. The first level included a main entrance, large open common area, kitchen, dining room, staff offices and resident apartments, with additional resident apartments on the second and third level. Although emergency exit diagrams were posted throughout the facility and in residents' apartments on the inside of their apartment door, there was no evidence of signage posted or information regarding the licensee's emergency plan. On September 21, 2022, at approximately 1:26 p.m., licensed assisted living director (LALD)-B stated the EP plan, was a "work in progress," and stated the licensee recently purchased the emergency preparedness guidance offered by a provider group; however, needed to personalize the information with their own location and specifics of the property once they received it. The current emergency preparedness binder was located in the LALD's office, which LALD-B verified was not posted prominently, as required. The plan included a hazard & vulnerability summary, which identified fire and weather-related events as probable events, and included response guidance for each of these identified events. In addition, the plan included a communication plan and LALD-B stated the licensee was part of the healthcare coalition in their region; however, the EP Plan lacked the following content: - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - safe evacuation from the facility including transportation; - sheltering in place for residents, staff, and	0 680		

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0 680	Continued From page 6 volunteers who remain in the facility; - use of volunteers; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - a communication plan that included: - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and the ability to provide assistance to include information about their occupancy; -a method of sharing information from the emergency plan with residents and their families; - EP training program for staff; and - EP testing/annual testing requirements. On September 21, 2022, at approximately 1:30 p.m., LALD-B verified the above missing content. The licensee's Disaster Planning and Emergency Preparedness policy, dated August 1, 2021, indicated a written emergency disaster plan that contained a plan for evacuation, addressed elements of sheltering in place, identified temporary relocation sites, and detailed staff assignments in the event of a disaster or emergency would be incorporated into the Appendix Z requirements and the licensee would provide emergency and disaster training to all staff during orientation and annually. The licensee's Emergency Preparedness Plan-Appendix Z Compliance, dated August 1, 2021, indicated the licensee's emergency preparedness plan would include all required elements of Appendix Z. No further information was provided.	0 680		

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0 680	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) 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 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 complied with fire protection requirements. This had the potential to directly affect all residents and staff.	0 780		

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0 780	Continued From page 8 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 September 19, 2022, between 11:00 a.m. and 1:00 p.m., survey staff toured the facility with the assistant (A)-C. During the facility tour, survey staff observed the following: 1. When smoke alarms in resident apartment 311 were tested by the A-C, none of the other alarms within the dwelling unit were activated. During the tour interview, A-C confirmed that smoke alarms were not interconnected within dwelling units so that actuation of one alarm caused all alarms in the dwelling unit to operate. 2. Smoke alarms were not installed in the sleeping rooms of apartments 106 and 322. During the tour interview, A-C confirmed that smoke alarms were not installed in these sleeping rooms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of	0 800		

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0 800	Continued From page 9 good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 19, 2022, between 11:00 a.m. and 1:00 p.m., survey staff toured the facility with the assistant (A)-C. During the facility tour, survey staff observed the following: 1. The 'PUSH TO OPEN" door button on the wall for the back patio was loose with capped electrical wires exposed. The A-C confirmed during the tour interview that this required repair. At approximately 2:00 p.m., survey staff observed that this door button had been secured to the wall and that wires were no longer exposed. TIME PERIOD FOR CORRECTION: One (1) day 2. One electrical outlet was not provided with a cover in resident apartment 106. 3. Water was leaking into the basement in a	0 800		

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0 800	Continued From page 10 resident storage area marked for apartments 219 and 321. Water was observed on the floor and dripping onto a mattress stored in this area. 4. The ceiling was water damaged in the following areas: a. Part of a ceiling tile was missing in the bedroom of apartment 113. Pieces of wet tile were noted on personal items and the floor under this area. The remaining part of the ceiling tile was observed as wet. b. Water-stained ceiling tiles were noted in the closets of apartments 109 and 208. c. Several ceiling tiles in the resident dining room and housekeeping rooms on the first and second floors were water stained. 5. One ceiling tile was missing in the living room above the window in resident apartment 322. The A-C confirmed during the tour interview that these items required repair. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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0 810	Continued From page 11 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to maintain the plans for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 19, 2022, at approximately 1:30	0 810		

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	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 12 p.m., the licensed assisted living director (LALD)-B provided documents for review. Documents were reviewed by survey staff on September 19, 2022, between 1:30 p.m. and 2:15 p.m. 1. The fire safety and evacuation plans were not maintained. Smoke compartment doors and fire doors on magnetic holders were referenced but not identified. 2. The fire safety and evacuation plans failed to include the identification of unique or unusual resident needs for movement or evacuation. On September 19, 2022, at approximately 2:30 p.m., the LALD-B confirmed during an interview that the fire safety and evacuation plans required revision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910		

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	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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0 910	Continued From page 13	0 910		

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R8, R9).

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

The findings include:

The licensee lacked a written contract with the following required content:
-the contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:
- the managing agent of the facility, if applicable; and
- the authorized agent for the facility.

R8's Assisted Living Contract, effective August 1, 2021, and signed by the resident April 7, 2022, indicated the licensee's managing agent was licensed assisted living director (LALD)-B and included the address of the facility; however, the contract lacked the telephone number as required. Also, the authorized agent was listed with the address of the facility; however, the contract lacked the authorized agent's telephone number as well.

R9's Assisted Living Contract, effective August 1, 2021, and signed by the resident May 25, 2022,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 910	Continued From page 14 indicated the licensee's managing agent was licensed assisted living director (LALD)-B and included the address of the facility; however, the contract lacked the telephone number as required. Also, the authorized agent was listed with the address of the facility; however, the contract lacked the authorized agent's telephone number as well. On September 21, 2022, at approximately 2:20 p.m., licensed assisted living director (LALD)-B verified the contract lacked the telephone numbers for the managing agent and the authorized agent for the facility, as required. LALD-B verified all residents received the same contract. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, indicated a signed Assisted Living contract would be received by the facility when a prospective resident decided to move into the facility; however, the policy lacked direction including the required contents of the contract. The licensee's Assisted Living License Resource Manual Assisted Living Contract Suggested Table of Contents, dated June 2021, indicated the summary and information cover sheet should include the name, address, and phone number of the managing agent (if applicable), and the name, address, and phone number of the authorizing agent. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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01610	Continued From page 15	01610		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for one of four residents (R6) as required. 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).	01610		

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	20347	A. BUILDING: _____ B. WING _____	09/21/2022

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01610	Continued From page 16 The findings include: During the entrance conference on September 19, 2022, at approximately 10:50 a.m., clinical nurse specialist (CNS)-A stated it was her practice to close/complete the initial assessment within 72 hours of when the resident moved in. R6's record lacked evidence the RN completed a nursing assessment of the physical and cognitive needs of the resident prior to the date on which the resident executed a contract with the licensee or the date on which the resident moved in, whichever was earlier, as required. R6 admitted on March 1, 2022, and received services under the licensee's assisted living license. R6's diagnoses included congestive heart failure (CHF), when the heart does not pump blood as well as it should. R6's Service Plan (Waiver) - Addendum to Contract dated August 17, 2022, indicated the resident received services including behavior monitoring, medication management and oxygen reminders. R6's Assessment As Of Date identified as the admission assessment, was dated March 4, 2022. The assessment indicated it was completed in person by CNS-A on March 4, 2022, three days after R6 moved in. On September 21, 2022, at approximately 3:21 p.m., CNS-A stated she starts the assessment on the date the resident moves in, but does not always complete it on the same day.	01610		

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	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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01610	Continued From page 17 The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, noted the licensee would conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moved in, whichever was earlier. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620		

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	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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01620	Continued From page 18 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services for one of four residents (R7). 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: During the entrance conference on September 19, 2022, at approximately 10:50 a.m., clinical nurse specialist (CNS)-A stated it was her practice to close the initial assessment within 72 hours and to re-assess at 14 days, every 90 days, and with a change in status. R7's record lacked evidence the RN completed a comprehensive assessment no more than 14 days after the initiation of services. R7 admitted on May 13, 2022, and received services under the licensee's assisted living license.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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01620	Continued From page 19 R7's diagnoses included bipolar disorder, high blood pressure and anxiety. On September 21, 2022, at approximately 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-H perform a blood glucose check and administer medications to R7 in his apartment. R7's Assessment As Of Date identified as the "14 day ER [emergency room] return", was dated May 31, 2022, 18 days after the initiation of services. R7's Service Plan (Waiver) - Addendum to Contract dated August 24, 2022, indicated services including assistance with dressing, medication management and blood glucose monitoring. On September 21, 2022, at approximately 2:50 p.m., CNS-A verified the assessment was not completed within the required 14 days, and stated she thought it had to be opened and started by that date. In addition, CNS-A stated they added the ER visit information to the 14 day assessment since the assessment was still in progress. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, noted resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01780	Continued From page 20	01780		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement policies and procedures for giving accurate and current medications for those residents who received medication management services during planned times away from home. This had the potential to affect all 55 residents receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

(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
01780	Continued From page 21 During the entrance conference on September 19, 2022, at approximately 10:50 a.m., licensed assisted living director (LALD)-B and clinical nurse specialist (CNS)-A confirmed the licensee provided medication management services to 55 of the 56 residents. On September 20, 2022, at approximately 2:05 p.m., during an observation, unlicensed personnel (ULP)-F stated to the surveyor she was going to set up medications for a resident with plans to go out on leave through Monday, but she stopped as the plans had changed. ULP-F stated she had been trained to do the task and typically she was the one to do the medication set up, even when the nurse was available, whether it was a planned or unplanned time away. Registered nurse (RN)-E, who was also present, stated she was not aware of the requirement for medications to be set up by a nurse or pharmacist for planned time away. On September 20, 2022, at approximately 2:20 p.m., CNS-A stated if a nurse was "available" they would set the medications up, but if the nurse was on the phone or doing an order the ULP would do the set up. The licensee's Medication Management - Planned & Unplanned Time Away policy noted for a planned time away, the medications mush be obtained by the pharmacy or set up by a licensed nurse. The policy also noted for unplanned times away when a pharmacist or licensed nurse was not available, the RN may delegate this task to the ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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01780	Continued From page 22 days	01780		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing a prescription label with legible information for two of three residents (R11 and R12) with insulin pens. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on September 19, 2022, at approximately 10:50 a.m., licensed assisted living director (LALD)-B and clinical nurse specialist (CNS)-A confirmed the licensee provided medication management services to 55 of the 56 residents.	01890		

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	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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01890	Continued From page 23 On September 20, 2022, at approximately 12:45 p.m., the surveyor conducted an observation and review of the licensee's medication refrigerator in the presence of licensed practical nurse (LPN)-I, who confirmed the findings. The licensee's medication area refrigerator contained four Lantus SoloStar pens on the top shelf of the refrigerator. One pen was marked for R9, with a corresponding box available in the refrigerator with the prescription information on it. One pen was unable to be identified. One pen was marked for R11, and one pen was marked for R12. LPN-I verified there were no boxes or prescription labels for the three additional Lantus SoloStar insulin pens. On September 21, 2022, at approximately 2:25 p.m., CNS-A stated the insulin pens should not have been stored in that refrigerator loose like they were, or at all after they had been opened. The licensee's Medications - Prescription Drugs & Prohibition policy dated August 1, 2021, noted prior to being set up for immediate or later administration, the prescription drug must be kept in the original container in which it was dispensed by pharmacy with the original prescription label with legible information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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02310	Continued From page 24 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for five of twenty residents (R1, R2, R3, R4 and R5). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: State statute 144.414 Prohibitions; Subdivision 3 Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. During the initial tour on September 19, 2022, at approximately 12:00 p.m., with clinical nurse specialist (CNS)-A, the surveyors observed an	02310	On September 21, 2022, the immediacy of correction order 2310 was removed, however non-compliance remained at a level 3/widespread violation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 25	02310		

external door, which was described by CNS-A as used by the residents who smoked. CNS-A stated they had a key to use to get back into the facility, as that door was locked. In addition, there was a buzzer there so staff could assist people in if needed, as there was a ramp access through this door.

On September 19, 2022, at approximately 1:35 p.m., the engineering surveyor reported to the surveyor team that during her tour between 11:00 a.m. and 1:00 p.m., she asked facility staff where residents smoked, and assistant (A)-C stated most residents smoked outside in the smoking area, but some residents were allowed to smoke in their apartments if they had been "grandfathered" in before the regulations went into effect.

R1
R1 admitted to the facility on February 28, 2012.

R1's diagnoses included high blood pressure and chronic obstructive pulmonary disease (COPD).

R1's Service Plan (Waiver) - Addendum to Contract dated August 17, 2022, indicated R1 received services including behavior monitoring, assistance with dressing and grooming, safety checks twice daily, medication management and blood glucose monitoring.

On September 19, 2022, at approximately 3:48 p.m., the surveyor observed R1's room with unlicensed personnel (ULP)-D. Upon arrival, R1 was in the hallway outside of his room, on a motorized scooter, visiting with another resident. R1 agreed to have his apartment observed, and accompanied ULP-D and the surveyor in his apartment. R1's room was cluttered and smelled

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	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 26	02310		

of cigarette smoke. R1 stated he does smoke in his room and that he was "grandfathered" in. The surveyor observed numerous burn holes in the carpet, and holes in R1's sweatpants, which he stated was from wear. R1 stated the burn holes in the carpet were there for 60 years, and were not from him. R1 has a long full beard on his face. R1 also stated he has two fire extinguishers in his room, but was not sure where they were. The surveyor observed a pillow on the recliner with a burn hole in it. In addition, R1's room had an oxygen concentrator at the end of his bed, an Everflow by Respironics, not plugged in, which R1 stated he does not use.

R1's prescriber orders dated September 16, 2022, included an order for oxygen one liter per nasal cannula with activity. It also noted the device type to be a concentrator and portable gas as the resident is mobile.

R1's Assessment As Of Date dated September 17, 2022, noted R1 smoked 1/2 to one pack per day and is able to handle and extinguish the cigarette responsibly. The assessment indicated there were no burns in the carpet, on the furniture or on the resident's clothing. It also noted "Education provided that he can not [sic] smoke in apartment with oxygen present even if oxygen is turned off." Smoking was not noted as a vulnerability for R1 on the assessment.

R1's Individual Abuse Prevention Plan dated September 17, 2022, noted resident smokes, but lacked any comments or plan of action.

R2
R2 admitted to the facility on June 15, 2011.

R2's diagnoses included type 2 diabetes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20347	A. BUILDING: _____ B. WING _____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLIGHT GARDENS APARTMENTS LL	501 1ST STREET NORTH SAINT CLOUD, MN 56303

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02310	Continued From page 27 R2's Service Plan (Waiver) - Addendum to Contract dated August 25, 2022, indicated R2 received services including behavior monitoring, assistance with dressing, safety check three times per day, medication management and blood glucose monitoring. On September 19, 2022, at approximately 4:06 p.m., the surveyor observed R2's room with ULP-D. R2 was not in his room at the time. The room appeared tidy. ULP-D confirmed R2 smokes in his room. The surveyor observed R2's recliner had burn marks, and the vinyl flooring had burn holes. ULP-D stated R2 often walked between the living room area and the back window, and burn marks were noted on the carpet in this pathway. R2's Assessment As Of Date dated September 6, 2022, noted R2 "Smokes in apartment, has not had any incidents with inappropriate smoking or fires in apartment due to inappropriate smoking", is able to handle and extinguish the cigarette responsibly. The assessment also noted no signs were in the apartment of mishandled cigarettes such as burn in carpet or furniture, and no burns on resident's clothing. Smoking was not noted as a vulnerability for R2 on the assessment. R2's Individual Abuse Prevention Plan dated September 6, 2022, noted "Resident smokes. See smoking assessment. Has no known incidence [sic] of unsafe smoking practices since move in." R3 R3 admitted to the facility on March 28, 2012. R3's diagnoses included high blood pressure.	02310		

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	20347	A. BUILDING: _____ B. WING _____	09/21/2022

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02310	Continued From page 28 R3's Service Plan (Waiver) - Addendum to Contract dated February 1, 2022, indicated services including behavior monitoring and safety checks twice daily. On September 19, 2022, at approximately 4:06 p.m., with permission from R3, the surveyor observed R3's room with ULP-D. Although burn holes were evident on R3's comforter, R3 denied they were burn holes. In addition, R3 stated she smokes in her living room, but never her bedroom, and added she was "grandfathered" in. In addition, the surveyor observed burn holes in the carpet in the sitting area. R3's Assessment As Of Date dated September 6, 2022, noted R3 smoked indoors and outdoors with no concerns, is able to handle and extinguish the cigarette responsibly, and no burn marks were noted in the carpet, furniture or on R3's clothing. Smoking was not noted as a vulnerability for R3 on the assessment. R3's Individual Abuse Prevention Plan dated September 6, 2022, noted "Resident smokes." Under Comments/Plan of Action was noted "Yes." However, the individual abuse prevention plan contained no plan of action or additional information related to smoking safety. R4 R4 admitted to the facility on October 29, 2012. R4's diagnoses included type 2 diabetes. R4's Service Plan (Waiver) - Addendum to Contract dated August 25, 2022, indicated services including assistance with bathing, behavior monitoring, medication management,	02310		

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	20347	A. BUILDING: _____ B. WING _____	09/21/2022

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02310	Continued From page 29	02310		

blood glucose monitoring and a safety check three times per day.

On September 19, 2022, at approximately 3:36 p.m., with R4's permission, the surveyor observed R4's room with ULP-D and R4. The surveyor observed an ashtray on the coffee table and several burn holes in the carpet by the couch. ULP-D stated R4 and the burn holes had been there for years, and added R4 typically smokes back in his sleeping area. The surveyor observed a recliner in the sleeping area with a brown throw blanket that had several burn holes. The carpet in front of the recliner also had many burn holes. In addition, burn holes were present in the recliner's back cushion. ULP-D stated R4 sometimes smoked in bed, but no burn holes were evident. R4 stated he only smokes in his recliner by the ashtray, and rolls his own cigarettes.

R4's Assessment As Of Date dated July 21, 2022, noted R4 smoked one pack per day, outside. It also noted R4 is able to handle and extinguish the cigarette responsibly, but burned spots were found in November 2021 on the carpet in front of the couch. R4 was encouraged in April 2022 to smoke outdoors, but no new concerns were noted in apartment at that time. Smoking was not noted as a vulnerability for R4 on the assessment.

R4's Individual Abuse Prevention Plan dated July 21, 2022, noted resident smokes, however, the individual abuse prevention plan contained no plan of action or additional information related to smoking safety.

R5
R5 admitted to the facility on February 3, 2020.

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02310	Continued From page 30 R5's diagnoses included schizophrenia and lung cancer. R5's Service Plan (Waiver) - Addendum to Contract dated August 1, 2021, indicated services including assistance with bathing, behavior monitoring, assistance with dressing, medication management, and a safety check three times daily. On September 11, 2022, at approximately 4:04 p.m., with R5's permission, the surveyor observed R5's room with ULP-D and R5. An oxygen sign was present on the door, and the surveyor observed an oxygen concentrator by Devilibis Health Care was in the room, unplugged. R5 stated she has not used the oxygen in four to five months, and she smokes outside, but used to smoke in her room. She stated she has not smoked in her room for "a while." R5 stated she never smoked in her sleeping area. The surveyor observed the dining room chair had a large burn hole, and the table and carpet in the dining room had numerous burn holes. When asked about the burn holes, R5 stated, "cheap cigarettes, the rolly kind, the cherry falls off." R5 stated she rolls her own cigarettes. Upon exiting the room, ULP-D stated, "Last week or the week before, we had to talk to her about smoking in her room because it was a daily issue." In addition, ULP-D stated residents who are not "grandfathered" in go into rooms of those who are and smoke. R5's Assessment As Of Date dated September 9, 2022, noted multiple times resident had been found smoking in her apartment with oxygen in the apartment. It also noted resident handled and extinguished the cigarette responsibly outside, and is not supposed to smoke cigarettes in her	02310		

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02310	Continued From page 31	02310		

apartment. In addition, resident was not allowed to smoke in her apartment, safety checks were in place and if observed to be smoking, she would be asked to put it out immediately. It was documented there was an incident on September 9, 2022, however smoking was not noted as a vulnerability for R5 on the assessment.

R5's Individual Abuse Prevention Plan dated September 9, 2022, noted resident smokes. In addition, R5 had incidents of smoking in her apartment, and has oxygen in the apartment. R5 had been provided education on risk of eviction should she be found smoking in her apartment, and the danger of injury and or death she posed to herself and others by smoking in her apartment. It also noted the incident on September 9, 2022. However, it contained no plan of action or contained no additional information related to smoking safety.

R5's Resident Notes from March 21, 2022, through September 14, 2022, contained the following documentation related to smoking:
- April 8, 2022, CNS-A was notified R5 had burn holes in the second bedroom carpet, and when CNS-A entered, an odor of cigarettes was noted. R5 stated she only smoked in her apartment sometimes and her oxygen concentrator was unplugged. The concentrator was verified to be unplugged. Education provided that R5 could not smoke in her apartment. R5 stated her friend burned the holes in the carpets. The note indicated it would be the final warning given to R5 due to the safety concern, and the eviction process would begin if found to occur again. Information was given on smoking cessation, but R5 was not interested in quitting.
- April 28, 2022, a pre-termination meeting was held due to risk of smoking in the apartment, and

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02310	Continued From page 32	02310		

safety concerns for R5 and others. R5 stated she smokes in her apartment at times due to not feeling well.
- May 1, 2022, staff noted smoked cigarette butts and spilled tobacco and tubes on the dining room table in R5's apartment.
- August 6, 2022, R5 had been observed by staff to be smoking in a peer's apartment when lunch trays were delivered, and in her own apartment when supper trays were delivered.
- August 7, 2022, R5 observed smoking in her room.
- September 5, 2022, R5 found smoking in a peer's room.
- September 9, 2022, staff entered R5's apartment to smell something burning. Staff documented, "Resident was passed out on couch with a lighter in hand. There was rolling device in front of her on coffee table and a burnt box of tubes. The tubes were all Ash. Now this is located less than 5 ft [feet] away from oxygen concentrator. When write a [sic] return with oximeter to check her oxygen stats [sic]. Resident was cleaning up the box of Ash and acting as if she did not know what happened. Writer told her will [sic] you had a fire I can see that you're trying to clean it up. But I have removed all of your tobacco and tubes from your room tonight and you can talk to the nurse in the morning."
- September 9, 2022, CNS-A and licensed assisted living director (LALD)-B "spoke with resident about the fire that occurred in her apartment from her smoking in apartment, which she is aware she is not to do. There has been previous meeting on this in which locking tobacco products up was the found solution per residents requests, however this was not effective as resident obtains other lighters/products. Resident was informed we would need to follow with eviction due to this incident as she is not a safe

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02310	Continued From page 33	02310		

smoker and has not been willing to quit smoking in her apartment. Resident has also been informed she can not [sic] smoke anywhere in building this included other apartments, she has been educated that she is not a safe smoker."
- September 9, 2022, R5 observed in a peer's room, smoking a cigarette on the couch.
- September 9, 2022, R5 found smoking in a peer's room.

On September 19, 2022, at approximately 1:50 p.m., CNS-A stated some residents had been "grandfathered" in to smoke in their apartments. She stated R1 was started on oxygen a couple weeks ago, and was no longer able to smoke in his room. CNS-A stated one incident was noted after he started on oxygen to be smoking in his room, however the oxygen concentrator was not plugged in, and was ordered with activity.

On September 19, 2022, at approximately 3:20 p.m., CNS-A stated R5 has been found smoking in her room, and they had tried alternatives such as locking up cigarettes, but had started the eviction process with R5. CNS-A stated the management company took over in 2011 and grandfathered those residents that smoked at that time inside to allow them to continue. R5 continues to smoke in her room with oxygen in the room but not on. In addition, CNS-A stated R5 has nodded off with a lit cigarette, but the oxygen was not present on her at that time. CNS-A also stated R1 recently returned with oxygen and had been educated about not smoking in his apartment with the oxygen in there. CNS-A stated R1 was under the understanding he could smoke in his apartment as long as the oxygen was unplugged, and she informed him this was not accurate. CNS-A added they are working on alternative placement for R1 due to smoking

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02310	Continued From page 34 unsafely. The U.S. Food & Drug Administration (FDA) Pulse Oximeters and Oxygen Concentrators: What to Know About At-Home Oxygen Therapy dated February 19, 2021, instructed when using an oxygen concentrator - do not use the concentrator, or any oxygen product, near an open flame or while smoking. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. On September 19, 2022, LALD-B and CNS-A stated the licensee had no policy related to smoking. The licensee's Oxygen policy, undated, noted "Smoking shall not be permitted within five feet of oxygen storage or oxygen in use." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *09/19/22*
Time: 12:09:08
Report: 7989221188

Food and Beverage Establishment Inspection Report

Location:
Skylight Gardens Apartments Ll
501 1st Street North
St Cloud, MN56303
Stearns County, 73

Establishment Info:
ID #: 0038054
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202594584
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

3-302.12

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

LABEL FLOUR/SUGAR CONTAINERS WITH COMMON INGREDIENT

Comply By: 09/19/22

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

3-305.11A

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

STORE ALL BOXES IN THE WALK-IN FREEZER UP OFF THE GROUND

Comply By: 09/19/22

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

INVERT SOUP SPOONS AND ALL UTENSILS TO ALLOW FOR HANDLES TO FACE UPWARD

Comply By: 09/19/22

Surface and Equipment Sanitizers

Chlorine: = 50 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: PREP
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 173 Degrees Fahrenheit - Location: SOUP
Violation Issued: No

Process/Item: Hot Holding
Temperature: 163 Degrees Fahrenheit - Location: BURGER
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: SOUP
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: BEANS
Violation Issued: No

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

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 7989221188 of 09/19/22.

Certified Food Protection Manager: MICHELLE LYNN MACE

Certification Number: 36191 Expires: 09/06/25

Signed: _____
Establishment Representative

Signed: Tyffani Maresh

Tyffani Maresh
Public Health Sanitarian
St Cloud
320-223-7361
Tyffani.Maresh@state.mn.us

Report #: 7989221188

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0	Date	09/19/22
No. of Repeat RF/PHI Categories Out	0	Time In	12:09:08
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Skylight Gardens Apartments LI	501 1st Street North	St Cloud, MN	56303	3202594584

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038054		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

					COS	R
Safe Food and Water						
30	IN	OUT	(N/A)	Pasteurized eggs used where required		
31				Water & ice obtained from an approved source		
32	IN	OUT	(N/A)	Variance obtained for specialized processing methods		
Food Temperature Control						
33				Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	(N/A) N/O	Plant food properly cooked for hot holding		
35	IN	OUT	N/A (N/O)	Approved thawing methods used		
36				Thermometers provided & accurate		
Food Identification						
37	X			Food properly labled; original container		
Prevention of Food Contamination						
38				Insects, rodents, & animals not present		
39	X			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	X	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:** 09/19/22

Inspector (Signature) Tyffani Marcel