Electronically Delivered

August 2, 2022

Administrator
Scandia House of Mora
973 Maple Avenue East
Mora, MN 55051

RE: Project Number SL26502015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 20, 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, 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.

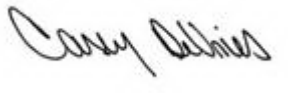
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.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

Please address your cover letter for general 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

Free from Maltreatment reconsideration 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

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
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26502	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA HOUSE OF MORA	973 MAPLE AVENUE EAST MORA, MN 55051

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL26502015-0 On July 18, 2022, through July 20, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were 11 residents receiving services under the Assisted Living with Dementia license.	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 Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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

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0 470	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license. The facility was licensed for a capacity of 12 residents and had a current census of 11 residents. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured the facility could respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On July 19, 2022, at approximately 1:20 p.m., clinical nurse supervisor (CNS)-A verified the staff schedule observed by the surveyor posted on the office wall was the only document pertaining to staffing and confirmed a registered nurse had not developed a written staffing plan to include the above noted required content. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7)	0 470		

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0 470	Continued From page 3 days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 had the potential to affect all 11 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 480		

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0 480	Continued From page 4 The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 18, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (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: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 485		

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0 485	Continued From page 5 failed to ensure menus were available to the residents and failed to inform residents of menu changes. This had the potential to affect all 11 residents receiving services. 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: During the facility tour with unlicensed personnel (ULP)-B, on July 18, 2022, at approximately 10:20 a.m., the surveyor observed one monthly menu posted on a refrigerator, located in the kitchen away from the resident's view. On July 20, 2022, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed the menu posted on the refrigerator was the menu format used by staff and the menu was not posted prominently for residents to view or provided to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

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0 550	Continued From page 6 procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all 11 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: On July 18, 2022, during the facility tour at approximately 10:20 a.m., the surveyor observed facility common areas and noted the lack of required posting of the licensee's grievance procedure and information related to reporting suspected maltreatment to MAARC. In addition, there was no posting of the contact information	0 550		

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0 550	Continued From page 7 for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to MAARC. On July 20, 2022, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed the content noted above was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to display the original current license at the main entrance as required. 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:	0 570		

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0 570	Continued From page 8 On July 18, 2022, at approximately 10:00 a.m., upon entering the facility, the surveyor noted the license was not posted at the facility entrance as required. On July 18, 2022, at approximately 10:20 a.m., during the facility tour with unlicensed personnel (ULP)-B, the surveyor observed the license posted in the housing manager's office, located at the end of a hallway, opposite of the entrance to the facility. On July 20, 2022, at 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed the license was posted in an area not accessible to residents, visitors or staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.	0 580		

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0 580	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain documentation of quality management activity. This had the potential to affect all 11 residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On July 18, 2022, at approximately 1:15 p.m., the surveyor requested documentation of the licensee's quality management activity. Clinical nurse supervisor (CNS)-A stated the company leadership held meetings every week to review the activities of the facilities, however, documentation for the meetings had not been kept and was not available for review by the surveyor. The licensee's Quality Improvement policy dated May 9, 2019, indicated the licensee would establish a quality improvement program based on the organization's size and appropriate to the types of services provided in order to assure that effective, comprehensive and appropriate plans were operational for residents within the organization. Additionally, the policy indicated documentation of quality improvement activities would be maintained and updated as needed, but	0 580		

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0 580	Continued From page 10 not less than annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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 and interview, the licensee failed to post the required information to include: (1) Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and (2) Posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 11 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: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living and the information for reporting suspected maltreatment to MAARC. On July 18, 2022, at approximately 10:20 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-B and observed the common areas lacked the required posting for the 911 emergency number and the reporting number for MAARC. ULP-B confirmed the 911 number and MAARC information was not posted. On July 20, 2022, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed the 911 emergency number was not posted on or near the telephone located on the kitchen counter in the main area and the contact information or reporting number for MAARC was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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	26502	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA HOUSE OF MORA	973 MAPLE AVENUE EAST MORA, MN 55051

(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
0 660	Continued From page 12 (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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: 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). Additionally, the licensee failed to ensure it completed a facility TB risk assessment or identify a person in charge of the TB infection control program. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 660		

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0 660	Continued From page 13 TB RISK ASSESSMENT & DESIGNATION OF STAFF IN CHARGE OF TB PROGRAM On July 18, 2022, at approximately 1:30 p.m., the surveyor requested the facility's TB risk assessment. Clinical nurse supervisor (CNS)-A provided a blank TB staff screening template. CNS-A stated she thought she had a completed TB risk assessment, however, the risk assessment provided for review was a Minnesota Department of Health (MDH) TB risk assessment template that had not been completed. On July 20, 2022, at approximately 9:00 a.m., the surveyor asked CNS-A if she understood the TB risk assessment requirement and what was needed for the TB risk assessment. CNS-A stated, "not necessarily, we have screening sheets and policies." On July 20, 2022, at approximately 9:00 a.m., regional licensed assisted living director (RLALD)-F stated, "we have access to a consultant and the registered nurse (RN) would be the person in charge." The licensee's Tuberculosis Screening/Prevention policy dated May 9, 2019, indicated the facility would observe the recommended precautions related to TB prevention identified by the CDC and MDH to include the precautionary element of completing a TB risk assessment. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should perform an initial facility TB risk	0 660		

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0 660	Continued From page 14 assessment. A TB infection control program should include the following: written TB infection control procedures. HCWs (health care worker) education should focus on basic information about: your health care setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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	0 680		

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0 680	Continued From page 15 received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and post an emergency preparedness plan prominently. This had the potential to affect all 11 residents receiving services under the assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 18, 2022, at approximately 1:10 p.m., the surveyor requested to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. The licensee's emergency preparedness plan included emergency plans for a fire, severe weather procedure, and a procedure for tornado. The licensee's plan lacked the following content and/or policies and procedures to address: - a comprehensive program to include	0 680		

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0 680	Continued From page 16 man-made disasters, facility based (power, water etc.), infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - the facilities role in providing care and treatment at alternative sites; - the provision of subsistence needs for staff and residents; - a tracking system used to document locations of residents and staff; - an evacuation plan; - how the facility would provide a means to shelter in place for residents and volunteers; - the medical record documentation system the facility has developed to preserve resident information security and availability of records; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. In addition, the licensee lacked a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families	0 680		

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0 680	Continued From page 17 On July 20, 2022, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program and had not posted an emergency plan for residents, staff or visitors. The licensee's Emergency Preparedness policy dated May 9, 2019, indicated the facility would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730		

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0 730	Continued From page 18 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a resident record included a discharge summary for one of one discharged resident (R3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 730		

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0 730	Continued From page 19 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's diagnoses included congestive heart failure (CHF), anxiety and hypertension. R3 was admitted for services on December 14, 2015, and began receiving assisted living services on August 1, 2021. R3 was discharged on April 3, 2022. R3's record included a Discharge Summary, dated April 3, 2022, which lacked the following information: -a summary of the resident's stay that included diagnoses, course of illnesses, allergies, treatments and therapies, and pertinent lab, radiology and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral and functional status; and -a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications. On July 20, 2022, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed the discharge summary lacked the above information. The licensee's Discharge of Residents policy,	0 730		

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0 730	Continued From page 20 dated May 9, 2019, indicated a discharge summary would be completed by the registered nurse (RN) for all discharged residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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:	0 780		

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0 780	Continued From page 21 Based on observation and interview, the licensee failed to provide working required smoke alarms in the hallways near resident room #4 and the office. This has the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 19, 2022, approximately from 11:00 a.m. to 1:00 p.m., survey staff toured the facility with the maintenance staff (M)-E. During the facility tour, survey staff observed the following: 1) The smoke alarms located in the hallway near resident room #4 and the hallway near the office did not sound when activated by the M-E. The M-E confirmed the finding. 2) The smoke alarms were not maintained as required to ensure smoke alarms did not exceed 10 years from the date of manufacture. Survey staff observed the label on the back of smoke alarms near room #4 and the office with a manufactured date stamp, September 2008, when the M-E removed the units for assessment. The M-E agreed that the smoke alarms needed to be maintained to ensure smoke alarms did not exceed 10 years from the date of manufacture. The M-E verified the finding. On July 19, 2022, at approximately 1:30 p.m.	0 780		

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0 780	Continued From page 22 during the exit interview, survey staff explained the above findings to the M-E and the certified nurse supervisor (CNS)-A. The M-E and the CNS-A acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). 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	0 790		

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0 790	Continued From page 23 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 July 19, 2022, approximately from 11:00 a.m. to 1:00 p.m., survey staff toured the facility with the maintenance staff (M)-E. During the facility tour, survey staff observed the following: 1)The portable fire extinguisher mounted near the office did not meet the required minimum size rated type, 2-A:10-B:C. The label on the unit indicated it was a type 1-A:10-B:C. In addition, survey staff explained to the M-E that the mounting height allowed by the state fire code for extinguishers must be no more than 60 inches (5 feet) above the ground. 2)The portable fire extinguisher located in the kitchen was improperly placed on the floor beneath the hand sink and missing a pin. 3)The portable extinguishers were observed with no tags attached to indicate the required annual service and monthly inspections from this year, or any previous years. On July 19, 2022, at approximately 1:30 p.m. during the exit interview, survey staff explained the above findings to the M-E and the certified nurse supervisor (CNS)-A. The M-E and the CNS-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800	Continued From page 24	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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 July 19, 2022, approximately from 11:00 a.m. to 1:00 p.m., survey staff toured the facility with the maintenance staff (M)-E. During the facility tour, survey staff observed the following: 1) The front entry door into the living room of the facility consisted of door hardware that did not provide security from the public and/or unauthorized entry. This poses a safety risk to	0 800		

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0 800	Continued From page 25 residents and staff. This finding was evident as survey staff asked the M-E if they were able to lock the door from unwanted entry, and the M-E stated that this door is always unlocked 24 hours a day. The M-E agreed that the entry door should restrict unwanted entry. 2) In the mechanical room, survey staff observed the water softener backwash discharge line was submerged into the standpipe receptor which poses potential cross-connection and contamination of the building water system. The backwash line must discharge to the standpipe receptor through a proper air gap. 3) In the mechanical room, survey staff observed the integral backflow preventer (atmospheric vacuum breaker) on the faucet of the service sink located across from the water softener was broken and in need of replacement. This finding poses concerns of the building water supply system from potential cross-connection. The M-E verified the finding as he asked for the location of the broken backflow preventer on the faucet. 4) The oxygen cylinders in resident room #2 were not secured to prevent them from falling over and pose safety concerns to the resident. The storage and use of oxygen containers must be reviewed for compliance with the state fire code. On July 19, 2022, at approximately 1:30 p.m. during the exit interview, survey staff explained the above findings to the M-E and the certified nurse supervisor (CNS)-A. The M-E and the CNS-A acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 800		

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0 810	Continued From page 26	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one 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 provide all required content on	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26502	A. BUILDING: _____ B. WING _____	07/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA HOUSE OF MORA	973 MAPLE AVENUE EAST MORA, MN 55051

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0 810	Continued From page 27 the fire safety and evacuation plan, required training, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 19, 2022, at approximately 1:00 p.m., survey staff reviewed the facility's fire safety and evacuation plan, drill, and training documentation. The documentation review indicated the following: FIRE SAFETY AND EVACUATION PLAN 1) Discrepancies in resident room numbering were observed throughout the facility. The building floor plan layout room numbers and the posted numbers on the resident sleeping rooms did not match. For example, the floor plan indicated a resident room as "Bed 12" but the posted number on the resident room was #10. 2) The plan lacked fire protection procedures for residents. 3) The plan documentation lacked the specific procedures for employee actions to be taken in the event of a fire and fire protection procedures necessary for addressing all residents including any unique resident-specific situations during an evacuation such as residents who are cognitive impaired, wheelchair-bound, on walkers, and	0 810		

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0 810	Continued From page 28 needing assistance during an evacuation. FIRE AND EVACUATION DRILLS No policy or records were provided for review for compliance with the minimum number of required employee fire and evacuation drills performed to date for a minimum of two drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. TRAINING 1) No policy or records were provided to show the required employee training on fire safety and evacuation training consisting of the minimum of upon hire and twice a year. 2) No policy or records were provided to show the required training of residents that can self-assist in their evacuation on the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. On July 19, 2022, at approximately 1:30 p.m. during the exit interview, survey staff explained the above findings to the M-E and the certified nurse supervisor (CNS)-A. The M-E and the CNS-A acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760		

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01760	Continued From page 29 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure insulin was administered per the manufacturer's instructions for one of one resident (R2) observed during insulin administration and failed to ensure as needed (PRN) medications had documentation of effectiveness after administration for one of one resident (R1) with records reviewed. 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: INSULIN PEN NOT PRIMED PRIOR TO ADMINISTRATION R2's diagnoses included dementia. R2's care plan dated July 2022, indicated R2	01760		

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01760	Continued From page 30 received medication administration five times daily. R2's prescriber's orders for insulin dated May 12, 2022, directed sliding scale Humalog (brand name of insulin) subcutaneous up to four times daily before meals and at bedtime. On July 18, 2022, at approximately 11:40 a.m., the surveyor observed unlicensed personnel (ULP)-C obtain a blood sugar from R2 with a result of 184, and then prepare to administer R2's sliding scale insulin. R2's insulin was dispensed from a Humalog Kwik Pen. ULP-C dialed up 3 units, which was verified by the surveyor, however, ULP-C did not prime R2's insulin pen prior to dialing up the prescribed dose. ULP-C then administered R2's insulin. At 11:48 a.m., ULP-C acknowledged and stated "I forgot" to prime the insulin pen. ULP-C stated she was taught by the registered nurse (RN) to prime the insulin pen prior to administration. The employee record indicated ULP-C had computer-based training completed May 10, 2021, on both insulin administration and insulin pens. Insulin competencies were completed with the RN on May 19, 2021. On July 18, 2022, at approximately 1:45 p.m., clinical nurse supervisor (CNS)-A stated prior to administration, the insulin pens need to be primed, and that was part of the skill competency for administering insulin. The manufacturer's instructions for the use of Humalog Kwik Pens, dated February 2019, directed for the insulin pen to be primed with two units prior to dialing the prescribed dosage to avoid injecting air and to ensure proper dosing.	01760		

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01760	Continued From page 31 PRN EFFECTIVENESS R1 was admitted for services on May 5, 2021, under the comprehensive license and began receiving services under the assisted living license August 1, 2021. R1's diagnoses included anxiety, chronic pain and chronic obstructive pulmonary disease (COPD). R1's Medication Assessment dated May 9, 2022, indicated R1 received medication administration four times daily and PRN. R1's PRN Medication Record for July 2022, indicated: - on July 6, 2022, R1 received Trazadone 25 milligram (mg) half tab for sleeplessness; - on July 8, 2022, Trazadone 25 mg half tab for anxiety and restlessness; - on July 11, 2022, Trazadone 25 mg half tab for restlessness; - on July 14, 2022, Trazadone 25 mg half tab for restlessness; and - on July 16, 2022, Trazadone 25 mg half tab for anxiety. R1's PRN medication record lacked documentation of the effectiveness of the PRNs given. On July 20, 2022, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-A stated the expectation for ULP's when administering as needed medications is they should follow the medication administration record (MAR) and document the effectiveness of the medication. Additionally, CNS-A stated more training would be provided to staff.	01760		

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01760	Continued From page 32 The licensee's Medication Administration policy dated February 7, 2019, indicated residents of licensee's facility are entitled to the safe administration of medications by qualified personnel according to a written medication management plan. The policy did not address insulin administration. The licensee's Medication Documentation policy dated February 7, 2019, indicated each medication administered by licensee's staff would be documented into the resident record. Documentation would be complete, accurate and legible. The policy did not address PRN medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced	02040		

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02040	Continued From page 33 by: Based on observation, document review, and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect the residents from potential harm. This has the potential to directly affect all memory care residents receiving assisted living services 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 19, 2022, approximately from 11:00 a.m. to 1:00 p.m., survey staff toured the facility with the maintenance staff (M)-E. On July 19, 2022, at approximately 1:00 p.m., the licensee lacked the required site-specific hazard vulnerability assessment and mitigation plan to protect residents from harm. 1) The lack of site-specific local safety risks or potential hazard vulnerabilities identification such as resident elopement from resident room windows and doors, the risks of misuse by accessing the unsecured portable fire extinguishers or accessing the unsecured electric panel in the dining areas, safety risks from the heat or touching the gas fireplace, risks from entering the unsecured/unlocked mechanical	02040		

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02040	Continued From page 34 rooms and in contact with the hazard of chemical solutions and/or sharp objects, and potential risks around the property such as busy roads due to resident elopement. 2) The lack of mitigations to each assessed risk or vulnerability to ensure effective respondence to all potential local site hazards that could directly affect all memory care residents. Specific prevention measures to mitigate risks from the identified potential hazard and vulnerability assessment must be developed and documented in the plan for all potential harm from the property. On July 19, 2022, at approximately 1:30 p.m. during the exit interview, survey staff explained the above findings to the M-E and the certified nurse supervisor (CNS)-A. The M-E and the CNS-A acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans,	02110		

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02110	Continued From page 35 including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents with dementia care, 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	02110		

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02110	Continued From page 36 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative. The licensee held an assisted living with dementia care license through July 31, 2022, and was licensed for a bed capacity of 12 residents. On July 20, 2022, at 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed the inclusive list of dementia care policies and procedures had not been developed/implemented or provided to each resident and/or representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations;	02170		

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02170	Continued From page 37 (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an evaluation for an activity plan for two of two residents (R1, R2) with records reviewed. 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	02170		

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02170	Continued From page 38 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had a current assisted living with dementia care license. R1 R1's diagnoses included chronic pain, hypertension and major depressive disorder. R1's Nurse Reassessment dated June 30, 2022, indicated R1 required staff supervision for mobility with the use of an assistive device, needed hands-on assist of one with transfers, full assist with bathing and was dependent on staff for housekeeping, laundry, appointments and transportation. R1's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R1's record lacked the development of an individualized activity plan. R2 R2's diagnoses included dementia with behavioral disturbance.	02170		

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02170	Continued From page 39 R2's Care Plan dated July 2022, indicated R2 required staff to assist with ambulation for safety, one assist with all transfers, one assist with dressing, grooming, toileting, housekeeping, laundry and meal preparation. R2 was unable to go out unattended and required two-hour safety checks. R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked the development of an individualized activity plan. On July 20, 2022, at approximately 9:00 a.m., clinical nurse supervisor (CNS)-A confirmed an activity assessment was not completed for R1 or R2 or for the other current residents residing at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *07/18/22*
Time: 11:45:00
Report: 1017221123

Food and Beverage Establishment Inspection Report

Location:
Scandia House Of Mora
973 Maple Avenue East
Mora, MN55051
Kanabec County, 33

Establishment Info:
ID #: 0038304
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202663028
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.

2-100 Supervision

2-102.12AMN

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

THIS LOCATION DOES NOT HAVE A CFPM ON SITE - MORGAN IS CURRENTLY CERTIFIED BUT MOSTLY WORKS IN ISLE. EMPLOY A CFPM AT THIS LOCATION. FACT SHEET SENT WITH REPORT.

Comply By: 07/25/22

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 42 Degrees Fahrenheit - Location: CHICKEN LOCATED IN UPRIGHT COOLER
Violation Issued: No

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

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG, COOKING TEMPS.

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 1017221123 of 07/18/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed:_____

Establishment Representative

INSPECTOR ID # 1017

651-201-4500
health.foodlodging@state.mn.us

Report #: 1017221123

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	1	**Date**	07/18/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:45:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Scandia House Of Mora	**Address** 973 Maple Avenue East	**City/State** Mora, MN	**Zip Code** 55051	**Telephone** 3202663028

License/Permit # 0038304	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

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

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/19/22

Inspector (Signature)