Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 20, 2024

Licensee
The Gardens at St. Gertrude's
1850 Sarazin Street
Shakopee, MN 55379

RE: Project Number(s) SL30475015

Dear Licensee:

On May 17, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 22, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 22, 2024 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 22, 2024, found not corrected at the time of the May 17, 2024, follow-up survey and/or subject to penalty assessment are as follows:

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8 - $500.00

The details of the violations noted at the time of this follow-up survey completed on May 17, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on May 17, 2024, we identified the following violation(s):

1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

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

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

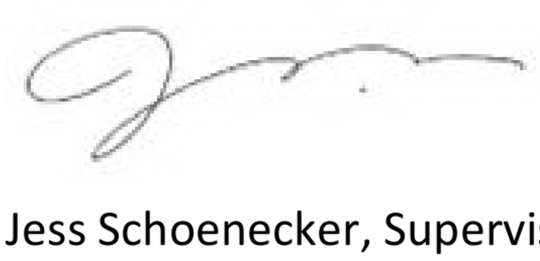
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30475	A. BUILDING: _____ B. WING _____	R 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GARDENS AT ST GERTRUDES	1850 SARAZIN ST SHAKOPEE, MN 55379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30475015-1 On May 15, 2024 through May 17, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 22, 2024. At the time of the survey, there were 39 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued/issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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 evaluators ' 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	

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{0 000}	Continued From page 1	{0 000}	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 780} SS=D	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: No further action required	{0 780}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 2 (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: No further action required	{0 810}		

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{01760}	Continued From page 3	{01760}		
{01760} SS=F	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 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 interview and record review, the licensee failed to document the reason why medication administration was not completed as prescribed and failed to document any follow-up procedures that were provided to meet the residents needs when medication was not administered as prescribed for two of two residents (R8, R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	{01760}		

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{01760}	Continued From page 4 R8 R8 was admitted to the licensee on February 20, 2024, to receive assisted living services. R8's signed service plan dated February 20, 2024, indicated that R8 received assistance with dressing, grooming, bathing, toileting, medication management, and medication administration. R8's physician order signed March 28, 2024, indicated the following orders: -Voltaren Arthritis Pain (diclofenac sodium) gel one percent; apply four grams (g); topical; apply to left hip and low back, three times per day. -Lidocare (lidocaine) adhesive patch; medicated; four percent; amount two patches; topical; on lower back and left hip pain; two patches, twice a day. -Ensure Plus eight ounces two times per day between meals at 10:00 a.m. and 3:00 p.m. -metoprolol tartrate 25 milligrams (mg); give 12.5 mg, oral, hold if systolic blood pressure less than 100; twice a day. R8's Medication Administration Record (MAR) dated May 1, 2024, through May 15, 2024, indicated the following: Medication Omissions: -Voltaren Arthritis pain gel was omitted from R8's MAR and R8's self-administration flowsheet dated May 1, 2024, through May 31, 2024. -Ensure Plus was omitted from R8's MAR and R8's self-administration Flowsheet dated May 1, 2024, through May 31, 2024. Medication Refusal: -Lidocare adhesive patch medicated; four percent, amount to administer: two patches; topical; once a day. R8's MAR indicated this medication was not administered for the month of	{01760}		

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{01760}	Continued From page 5 May. R8's record lacked documentation of any follow-up from when medication was not administered as prescribed. Transcription Error: -metoprolol tartrate tablet; 25 mg; amount to administer: ½ tablet; oral; twice a day. R8's MAR omitted instructions to hold medication if systolic blood pressure less than 100. R10 R10 was admitted to the licensee on April 16, 2024. R10's signed service plan dated April 16, 2024, indicated R10 received assistance with bathing, bathroom assistance, special care needs, medication management, and diabetic management. R10's physician order signed April 16, 2024, indicated the following orders: -nystatin powder; 100,000 unit/gram; dab (sic) topical, to abdominal skinfold erythema (redness) until resolved; twice a day. -ipratropium-albuterol; solution for nebulization; 0.5 mg - 3 mg (2.5 mg base)/3 milliliter (ml); inhale 3 ml; inhalation; four times per day. R10's Medication Administration Record (MAR) dated May 1, 2024, through May 15, 2024, indicated the following: Medication Refusals: -nystatin powder; 100,000 unit/gram; twice a day, topical to abdominal skin fold twice daily until redness/inflammation is resolved. R10's MAR indicated this medication was not administered for the month of May. R10's record lacked documentation of any follow-up from when medication was not administered as prescribed. -ipratropium-albuterol solution for nebulization;	{01760}		

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{01760}	Continued From page 6 0.5 mg - 3mg (2.5 mg base)/3 ml; inhale 3 ml; four times per day. R10's MAR indicated this medication was not administered for the month of May. R10's record lacked documentation of any follow-up from when medication was not administered as prescribed. On May 16, 2024, at 4:10 p.m., clinical nurse supervisor (CNS)-D indicated they were not aware of the medication errors and would provide additional education to the floor staff on refusals. CNS-D stated they have now notified the doctor and have requested new orders. On May 17, 2024, at 3:45 p.m., regional director (RD)-A indicated they have provided additional education to CNS-D on doctor orders. The licensee's Medication Errors policy dated August 1, 2021, indicated the following: Medication Error as the preparation or administration of drugs or biologicals which is not in occurrence with the attending providers' orders, manufacturer's specification or accepted standards and principles of the professional providing the services. Examples of medication errors include: - Omissions; - Unauthorized drug; - Wrong dose; - Wrong route of administration; - Wrong dosage form; - Wrong drug; - Wrong time; and - Failure to follow manufacturer's instruction (not shaking the medication or crushing medication on a no crush list). No further information was provided.	{01760}		

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01940	Continued From page 7	01940		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan with all required content for	01940		

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01940	Continued From page 8 two of two residents (R8, R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R8 R8 was admitted on February 20, 2024, with diagnoses of chronic diastolic congestive heart failure (CHF) and stage three chronic kidney disease. R8's Discharge/Transfer Orders dated February 20, 2024, indicated R8 had the following treatment orders: 1. Weight daily - if weight up three (in one day) or five pounds in seven days from admission. Call MD (medical doctor); once a day. 2. Medium compression tubigrip (special type of compression) on in AM (morning) and off at HS (night); twice a day. R8's signed service plan dated February 20, 2024, indicated R8 received nurse management of treatments, but lacked mention of which treatments were administered. R8's medication administration history (MAR) dated May 1, 2024, through May 15, 2024, was identified by the regional director (RD-A) as R8's evidence of treatment administration.	01940		

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01940	Continued From page 9 R8's record lacked resident specific instructions for daily weights and evidence of R8's compression tubigrip administration. R10 R10 was admitted on April 16, 2024, with diagnoses of CHF and chronic obstructive pulmonary disease (COPD). R10's Discharge/Transfer Orders dated April 16, 2024, indicated R10 had the following treatment orders: 1. Oxygen - continuous wean as able per nasal canula. To keep oxygen saturation greater than or equal to 90%. Current oxygen flow rates: O2 ((liters per minute) LPM): 3 every shift; days, evenings, nights 2. Weight daily in AM: call physician if weight increased by two pounds in 24 hours or five pounds in seven days from admission weight. R10's signed service plan dated April 16, 2024, indicated R10 received nurse management of treatments. R10's MAR dated May 1, 2024, through May 15, 2024, was identified by RD-A as R10's evidence of treatment management plan. R10's record lacked resident specific instructions for management of oxygen delivery and daily weights. On May 16, 2024, at 1:12 p.m., RD-A indicated in an email, the medication and treatment management plan for both R8 and R10 were included on the service plans. On May 17, 2024, at 3:45 p.m., RD-A stated they provided some further education to clinical nurse	01940		

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01940	Continued From page 10 supervisor (CNS)-D on physician orders earlier in the day. The licensee's Treatment and Rehabilitative Therapy Management policy, effective August 1, 2021, indicated the individualized treatment and therapy management record will include the following: a. A statement of the type of services that will be provided, b. Documentation of specific resident instructions relating to the treatments or therapy administration, c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel, d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services, and e. Any resident-specific requirements relating to documentation of treatment and therapy received verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident	01960		

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01960	Continued From page 11 record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to accurately transcribe provider's orders and ensure documentation of administration or the reason why a treatment was not administered and any follow-up procedures that were provided for two of two residents (R8, R10) receiving treatments. 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: R8 R8 was admitted on February 20, 2024, with diagnoses of chronic diastolic congestive heart failure (CHF) and stage three chronic kidney disease. R8's signed service plan dated February 20, 2024, indicated R8 received nurse management	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30475	A. BUILDING: _____ B. WING _____	R 05/17/2024

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01960	Continued From page 12 of treatments. R8's Discharge/Transfer Orders dated February 20, 2024, indicated R8 had the following treatment orders: 1. Weight daily - if weight up three (in one day) or five pounds in seven days from admission. Call MD (medical doctor); Once a day. 2. Medium compression tubigrip (special type of compression) on in AM (morning) and off at HS (night). Twice a day. R8's medication administration history (MAR) dated May 1, 2024, through May 15, 2024, identified by regional director (RD)-A as R8's evidence of treatment administration, indicated the following: 1. Daily vitals: BP (blood pressure), pulse, respirations, temperature, weight and O2 (oxygen) sats (saturation) once a day. Special instructions: Take a full set of residents (sic) vitals daily. R8's MAR lacked documentation of weights on May 1, 2024, May 7, 2024, May 9, 2024, May 12, 2024, and May 14, 2024. 2. Compression tubigrip administration was omitted from the MAR. R8's Clinical View Report run on May 15, 2024, had clinical notes dated February 21, 2024, through May 14, 2024, lacked documentation of any follow-up procedures that were provided to meet R8's needs when treatment or therapies were not administered as ordered or prescribed. R10 R10 was admitted on April 16, 2024, with diagnoses of CHF and chronic obstructive pulmonary disease (COPD). R10's signed service plan dated April 16, 2024,	01960		

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01960	Continued From page 13 indicated R10 received nurse management of treatments. R10's Discharge/Transfer Orders dated April 16, 2024, indicated R10 had the following treatment orders: 1. Oxygen (O2) - continuous wean as able per nasal canula. To keep oxygen saturation greater than or equal to 90%. Current oxygen flow rates: O2 ((liters per minute) LPM): 3 every shift; Days, Evenings, Nights 2. Weight daily in AM: Call physician if weight increased by two pounds in 24 hours or five pounds in seven days from admission weight. R10's MAR dated May 1, 2024, through May 15, 2024, identified by RD-A as R10's evidence of treatment management administration indicated the following: 1. O2 three LPM per nasal cannula continuous - wean off at greater than 90 percent, every shift. R10's MAR lacked documentation of oxygen administration every shift as ordered by the prescriber. Also, R10's MAR lacked any documentation of oxygen saturations to determine if resident could be weaned off of oxygen if saturation was greater than 90 percent. 2. Daily weight, call physician if weight increased by two pounds in 24 hours or five pounds in seven days. R10's MAR lacked documentation of weights every day except on May 2, 2024. R10's Clinical View Report run on May 15, 2024, had clinical notes dated April 16, 2024, through May 8, 2024, lacked documentation of any follow-up procedures that were provided to meet R10's needs when treatment or therapies were not administered as ordered or prescribed.	01960		

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01960	Continued From page 14 On May 17, 2024, at 3:45 p.m., RD-A stated they provided some further education to clinical nurse supervisor (CNS)-D on physician orders earlier in the day. The licensee's Medication and Treatment Orders - Receiving, Implementing, Renewal and Re-ordering policy dated August 1, 2021, indicated upon receipt of a medication and/or treatment order from the authorized provider, whether it is a new order or a change in an existing order, the licensed nurse will take action to implement the order. The licensee's Medication, Treatment, and Therapy administration - Licensed and Unlicensed Personal policy dated August 1, 2021, indicated under medication administration, licensed nurses, and trained unlicensed personnel's (ULP) will chart in each resident's MAR any problems with medication administration: ULP will notify the nurse of medications, treatment, or therapies refused, held, or dropped/soiled/spilled. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Electronically Delivered

April 2, 2024

Licensee
The Gardens At St. Gertrudes
1850 Sarazin St
Shakopee, MN 55379

RE: Project Number(s) SL30475015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

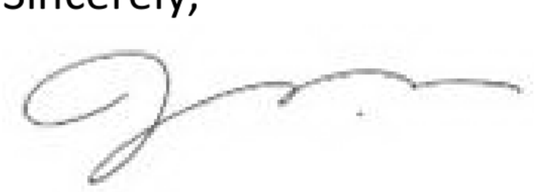
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL30475015-0 On February 20, 2024 through February 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 34 residents receiving services under the Assisted Living license. An immediate correction order was identified on February 21, 2024, issued for SL34075015-0, tag identification 1290. On February 21, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 1 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. 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) 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 February 20, 2024, at 11:40 a.m., during a tour of the facility, the surveyor observed the licensee lacked a posting of the contact person's	0 550		

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0 550	Continued From page 2 name, telephone number, and email information for the individual(s) who were responsible for handling resident grievances. On February 22, 2024, at 2:00 p.m., during the exit conference, housing director (HD)-B indicated the contact information was missing on the grievance posting and stated, "This should be an easy fix." The licensee's Concerns, Grievances policy revised on September 17, 2019, under section Policy: VIII., indicated the community social service lead is the grievance officer but lacked the person's name, telephone number, and email information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 780 SS=D	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;	0 780		

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0 780	Continued From page 3 (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 are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On February 21, 2024, at 9:30 a.m., survey staff toured the facility with the environmental service direct (ESD)-G and house manager (HD)-B. During the tour, it was observed that upon testing, the smoke alarms in two-bedroom resident units #238 and #220 were not interconnected, so the actuation of one smoke alarm would cause all other alarms in the unit to actuate.	0 780		

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0 780	Continued From page 4 On February 21, 2024, at 9:30 a.m., ESD-G verified that the smoke alarm in the small bedroom in unit #220 was not interconnected to other smoke alarms in the unit, and the smoke alarm in a bedroom in unit #238 was removed from the ceiling and was not interconnected to other smoke alarms in the unit. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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	0 810		

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0 810	Continued From page 5 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 the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 February 21, 224, at 10:30 a.m., environmental service direct (ESD)-G and house manager (HD)-B provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included standard resident evacuation	0 810		

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0 810	Continued From page 6 procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency, including individualized, unique needs of residents. The plan failed to include ways to move and evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on February 21, at 10:30 a.m., HD-B stated the FSEP was from the corporate office, and it was not updated to meet the facility-specific layout and evacuation procedure. HD-B verified the facility needed to update the FSEP, including the facility-specific evacuation and relocation procedure. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. Provided documentation indicated that the drills were conducted on 1/25/23 at 3:00 p.m. for the second shift, 3/31/23 at 5:05 a.m. for the night shift, 5/20/23 at 8:15 a.m. for the first shift, 8/1/23 at 3:00 p.m. for the second shift, 9/8/23 at 4:44 a.m. for the night shift, 9/11/23 at 12:30 a.m. for the night shift, 1/30/24 at 11:25 a.m. for the first shift, with no further drills being documented. During the interview on February 21, at 10:30 a.m., HD-B verified there were no further documented drills for the facility between September 2023 and January 2024 and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01290	Continued From page 7	01290		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for two of five employees (unlicensed personnel (ULP)-I, ULP-J). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-I	01290		

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	30475	A. BUILDING: _____ B. WING _____	02/22/2024

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01290	Continued From page 8 ULP-I was hired October 18, 2021, to provide assisted living services. ULP-I's background study affiliated to HFID 34075, indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 website roster page. The licensee's weekly schedule dated February 15, 2024, through February 21, 2024, indicated that ULP-I had worked unsupervised on the evening shift 2:30 p.m. to 9:45 p.m., on February 19, 2024, and the overnight shift from 10:30 p.m. to 5:45 a.m., on February 20, 2024. ULP-J ULP-J was hired April 1, 2015, and began providing assisted living services for the licensee on August 1, 2021. ULP-J's background study affiliated to HFID 34075 indicated that a current background check was in pending status with an application date and time of February 20, 2024, 10:35 a.m., as indicated in the NETStudy 2.0 facility background study roster. ULP-J's employee record lacked evidence to indicate the licensee had submitted a background study under the current assisted living license prior to the start of the survey. The licensee's weekly schedule dated February 15, 2024, through February 21, 2024, indicated that ULP-J had worked unsupervised on the evening shift 3:30 p.m. to 10:45 p.m., on February 16, 2024, February 17, 2024, February 18, 2024, and February 20, 2024. On February 21, 2024, at 11:30 a.m., regional	01290		

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01290	Continued From page 9 director (RD)-A stated that background checks are completed and maintained by human resources. On February 21, 2:40 p.m., RD-A and housing director (HD)-B stated that they were unaware that the background studies had not been completed prior to survey for ULP-J, and were not aware that background studies for ULP-I were expired. On February 21, 2024, Minnesota Department of Human Services website, "Background studies" indicated that DHS temporarily modified background studies during the COVID-19 pandemic. Those modifications ended January 1, 2023. On February 21, 2024, Minnesota Department of Human Services website, "Emergency background studies end" indicated that emergency studies are no longer valid. Individuals who only have an emergency study must have a fully compliant fingerprint-based background study. The Licensee's Background Checks policy dated March 3, 2022, indicated that employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. All employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		

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01290	Continued From page 10 On February 21, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an assessment not to exceed ninety calendar days from the previous	01620		

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01620	Continued From page 11 assessment for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R3 was admitted on April 27, 2023. R3's Resident Evaluation dated October 17, 2023, indicated next evaluation due date of January 9, 2024. R3's Resident Evaluation dated January 16, 2024, was completed ninety-one days from the previous assessment dated October 17, 2023. On February 22, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-D stated, "all assessments should be done every 90 days. The process [licensee] use is 90 days minus one week." On February 22, 2024, at 2:00 p.m., during the exit interview, regional director (RD)-A indicated licensee is aware of late assessments for multiple residents and licensee was working on getting assessments completed timely. The licensee's Initial and On-Going Assessments of Residents Policy No.: POL_MNAL 01.02 dated August 1, 2021, indicated frequency between assessments not to exceed ninety days from the last date of the assessment.	01620		

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01620	Continued From page 12 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01760 SS=E	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 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 that a physician order was transcribed accurately for one of eight residents (R8). In addition, the licensee failed to ensure that unlicensed personnel (ULP-E) followed appropriate medication administration procedures for one of eight 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) and was issued at a	01760		

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01760	Continued From page 13 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: TRANSCRIPTION ERROR R8 was admitted to the licensee on February 20, 2024, to receive assisted living services. R8's signed service plan dated February 20, 2024, indicated that R8 received assistance with dressing, grooming, bathing, toileting, medication management, and medication administration. R8's physician order signed February 20, 2024, indicated two patches applied to lower back and left hip twice per day at 7:00 a.m. to 10:00 a.m., and 7:00 p.m. to 10:00 p.m. On February 21, 2024, at approximately 8:00 a.m., during the morning medication pass, the surveyor observed ULP-F remove two lidocaine patches from R8 and place a new lidocaine patch on left lower back. The surveyor observed the new lidocaine patch was placed on R8 with no time and date of administration, or the name of person applying the patch. The manufacturer's instruction for Rugby Pain Relief Patches dated January 2023, indicated the following: - Do not use more than one patch on your body at a time; - Use one patch for up to 12 hours; and - Discard patch after single use. On February 22, 2024, at approximately 10:45	01760		

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01760	Continued From page 14 a.m., clinical nurse supervisor (CNS)-D stated that they had recalled transcribing the orders for R8's lidocaine patches and stated that they thought that the orders were abnormal for leaving the patches on for twenty-four hours at a time but did not seek further clarification from the prescribing physician. On February 22, 2024, at approximately 12:50 p.m., CNS-D provided further clarification on the order for lidocaine patches. CNS-D stated that their transcription system required two entries into their medication administration record (MAR). The first entry is used to notify staff to place the patch, and the second is to notify staff to remove the patch. CNS-D stated that they had forgotten to enter the second entry into the MAR to ensure that staff are notified to remove the lidocaine patches. MEDICATION ADMINISTRATION R7 was admitted to the licensee on October 25, 2022, to receive assisted living services. R7's signed service plan dated January 9, 2023, indicated that R7 received assistance with medication management and medication administration. R7's physician orders dated October 30, 2023, indicated that R7 was to receive 50 milligrams (mg) of Tramadol twice daily for leg pain. On February 22, 2024, at 10:33 a.m., during a medication cart audit, the surveyor observed that the current narcotic count book showed that a dose of Tramadol 50 mg tablet had been dispensed for R7 at approximately 10:00 a.m., with a remaining count of 9 tablets. The medication card had 10 tablets remaining.	01760		

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01760	Continued From page 15 At approximately 10:35 a.m., ULP-E stated that they had signed out the medication but had failed to remove the medication from the medication card. ULP-E was then observed removing the medication from the medication card, placing medication into a medication cup, and left to administer the medication to R7. On February 22, 2024, at approximately 10:40 a.m., CNS-D stated that it was his expectation that staff are to only sign off on narcotic medications while removing narcotic medications from locked storage. In addition, CNS-D stated that additional education will be completed with staff to ensure that this issue no longer occurs. The licensee's Medication Errors policy dated August 1, 2021, indicated the following: Medication Error as the preparation or administration of drugs or biologicals which is not in occurrence with the attending providers' orders, manufacturer's specification or accepted standards and principles of the professional providing the services. Examples of medication errors include: - Omissions; - Unauthorized drug; - Wrong dose; - Wrong route of administration; - Wrong dosage form; - Wrong drug; - Wrong time; and - Failure to follow manufacturer's instruction (not shaking the medication or crushing medication on a no crush list). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		

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01760	Continued From page 16 days	01760		

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

Type: Full
Date: *02/21/24*
Time: 10:30:00
Report: 8041241028

Food and Beverage Establishment Inspection Report

Location:
The Gardens At St Gertrudes
1850 Sarazin St
Shakopee, MN55379
Scott County, 70

Establishment Info:
ID #: 0039294
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522334400
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.

No NEW orders were issued during this inspection.

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

Met on site with Wiliam Sams (Operations Support Manager- Cura Hospitality). The food service area in this assisted living facility is ran by a third party, Cura Hospitality, and is licensed and inspected by MDH-FPLS #41250. Food service area was not inspected today.

Report sent the Health Regulation Division Nurse Evaluators competing the site survey, Zach Morth and Rhawnie Quinehan.

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 8041241028 of 02/21/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
William Sams
Operations Support Manager

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us