Electronically delivered

October 13, 2022

Administrator
Assured Care
13404 Knob Hill Road
Burnsville, MN 55337

RE: Project Number(s) SL33372015

Dear Administrator:

On September 19, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on June 24, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the June 24, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on June 24, 2022, found not corrected at the time of the September 19, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0800-Fire Protection And Physical Environment-144g.45 Subd. 2 (a) (4)

The details of the violations noted at the time of this follow-up evaluation completed on September 19, 2022 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

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 have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

We urge you to review these orders carefully. If you have questions, please contact Jessica Chenze at 218-332-5175.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jessie Chenze, RN, BSN
Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33372	A. BUILDING: _____ B. WING _____	R 09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED CARE	**13404 KNOB HILL ROAD BURNSVILLE, MN 55337**

(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 1144G.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: Project #SL33372015-1 On September 19, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 24, 2022. At the time of the survey, there were 3 active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	{0 510}		

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{0 510}	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}		
{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 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: No further action needed.	{0 550}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	{0 660}		

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{0 660}	Continued From page 2 (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: No further action needed.	{0 660}		
{0 800} SS=E	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 for the occupied upper-level back	{0 800}		

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{0 800}	Continued From page 3	{0 800}		

resident room. This has the potential to directly affect the health, safety, and well-being of future 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings are:

On September 19, 2022, approximately from 10:30 a.m. to 11:30 a.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, survey staff observed and the LALD-C verified the following findings for the upper-level back resident room (master bedroom):

-The carpet had multiple significant wrinkles creating potential tripping concerns. The LALD-C stated that she was prioritizing repair orders and was currently focusing her finance on egress window replacements first.
-The toilet paper holder and shower bar in the bathroom were not intact for use.

The licensee lacked documentation to support a schedule for the above repairs for the master bedroom.

On September 19, 2022, at approximately 12:15 p.m. during the exit interview, the LALD-C acknowledged the above findings. The LALD-C

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{0 800}	Continued From page 4 explained she will not occupy the master bedroom until the egress window and above repairs were made. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 800}		
{0 930} SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: No further action needed.	{0 930}		

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{01440}	Continued From page 5	{01440}		
{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action needed.	{01440}		
{01530} SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working	{01530}		

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{01530}	Continued From page 6 hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action needed.	{01530}		
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	{03090}		

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{03090}	Continued From page 7 This MN Requirement is not met as evidenced by: No further action needed.	{03090}		

Electronically Delivered

July 26, 2022

Administrator
Assured Care
13404 Knob Hill Road
Burnsville, MN 55337

RE: Project Number(s) SL33372015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 24, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = $3,000

The total amount you are assessed is $3,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# SL33372015 On, June 21 through June 24, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents, all of whom received services under the provider's Assisted Living license. On June 22, 2022, an immediate correction order was identified for SL33372015, tag identification 0820, and was issued to the licensee on June 23, 2022. On June 23, 2022, the immediacy of correction order 0820 was removed, however, non-compliance remained at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 510	Continued From page 1	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure appropriate personal protective equipment was worn while providing cares for one of one employee, unlicensed personnel (ULP)-F, observed to deliver cares to residents. This had the potential to affect all three (3) 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).	0 510		

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	33372	A. BUILDING: _____ B. WING _____	06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED CARE	13404 KNOB HILL ROAD BURNSVILLE, MN 55337

(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
0 510	Continued From page 2	0 510		

The findings include:

On June 22, 2022, during a continuous observation from 7:27 a.m. to 8:18 a.m., the following observations were made:
-at 7:27 a.m., ULP-F provided toileting cares and ambulation assistance for R1.
-at 7:43 a.m., ULP-F assisted R1 with blood glucose level testing.
-at 7:48 a.m., ULP-F assisted R1 with medication administration.
-at 8:08 a.m., ULP-F provided toileting cares and ambulation assistance for R1.
ULP-F wore a face mask, and prescription eyeglasses, but failed to wear eye protection during cares.

On June 22, 2022, ULP-F stated they always wore a mask when working. ULP-F further stated they have face shields they wore when COVID was more prevalent, and would wear the face shield with a COVID positive resident. ULP-F further stated "the state" indicated eyeglasses were ok to wear as eye protection.

On June 22, 2022, at 9:06 a.m., registered nurse (RN)-A stated employees would wear eye protection such as a face shield if there was a positive resident, a resident with symptoms, or when providing wound care, nebulizer treatment or other aerosolizing procedures. RN-A further stated they did not require eye protection because no cares of that type were provided, and no resident had symptoms.

The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7,

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0 510	Continued From page 3 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The CDC COVID Data Tracker on June 22, 2022, indicated Dakota County, MN (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents. The licensee's infection control policy, dated April 7, 2022, indicated, Assured Care will observe the recommended precautions for assisted living as identified by the Centers for Disease Control and Prevention (CDC). The precautions cover those residents with documented or suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The practice of employees will conform with OSHA regulations, current law and currently accepted health care, medical and nursing standards of practice for infection control." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
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 4	0 550		

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 and contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Mental Health and Developmental Disabilities. This had the potential to affect all (3) residents receiving assisted living services.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 June 21, 2022, at 10:35 a.m., the surveyor observed the common areas of the facility lacked a posting of the grievance procedure and OOLTC contact information.

On June 21, 2022, at 10:41 a.m., registered nurse (RN)-A acknowledged the grievance procedure was not posted, but stated "everyone

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0 550	Continued From page 5 is educated on the process". RN-A further acknowledged the OOLTC contact number was also not posted. The licensee's grievance policy, dated April 7, 2022, indicated, "A copy of the grievance procedure is conspicuously posted in the residence with the following information: -Name, phone number and email contact information for the individuals who are responsible for handling resident complaints -Contact information for the state and any regional Office of Ombudsman for Long-Term-Care -Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities: -Contact information for the Minnesota Adult Abuse Reporting Center". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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	0 660		

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0 660	Continued From page 6 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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of two employees (unlicensed personnel (ULP)-B) with employee 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 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: The Facility TB Risk Assessment dated April 27, 2022, identified the facility was at a low risk for transmission. ULP-B was hired November 25, 2019, and provided direct cares for the licensee's residents. ULP-B's employee record included a Tuberculin skin test (TST) dated November 25, 2019, however lacked a second step TST and history and symptom screening. On June 22, 2022, at 10:02 a.m., licensed	0 660		

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0 660	Continued From page 7 assisted living director (LALD)-C stated ULP-B's TB screening form and TB test documentation might be located in a stack of papers taken by a consultant for organizing of employee files, but did not provide the documentation. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening/Prevention policy, dated April 7, 2022, indicated employees would receive baseline TB screening upon hire to include an assessment for TB history and current TB symptoms, and a test using a two-step TST or blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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:	0 780		

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0 780	Continued From page 8 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnection of smoke alarms in the home. This has the potential to directly affect occupied 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:	0 780		

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0 780	Continued From page 9 On June 22, 2022, approximately from 1:15 p.m. to 3:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, survey staff observed the smoke alarms when tested failed to sound all smoke alarms throughout as required for interconnection of all smoke alarms for proper notification. The finding was evident when the smoke alarms located in the kitchen area, the resident rooms, and hallways were tested and sounded local. Survey staff explained to the LALD-C that when one smoke alarm is activated, all smoke alarms must sound throughout the home for notification. On June 22, 2022, approximately at 4:30 p.m., during the exit interview, the LALD-C 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	0 790		

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0 790	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the minimum size required for 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 occupied 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, 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 June 22, 2022, approximately from 1:15 p.m. to 3:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, survey staff observed the portable fire extinguishers were labeled with size 1-A:10-B:C with no annual service or monthly inspection records. Survey staff explained to the LALD-C that the minimum rated type must be 2-A:10-B:C, and all extinguishers must be serviced and inspected. These findings were verified with the LALD-C. On June 22, 2022, approximately at 4:30 p.m., during the exit interview, the LALD-C acknowledged the findings. No further information was provided.	0 790		

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0 790	Continued From page 11 TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
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 occupied 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, 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 are: On June 22, 2022, approximately from 1:15 p.m. to 3:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, survey staff observed During the	0 800		

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0 800	Continued From page 12 tour survey staff observed and the LALD-C verified the following findings: 1) UPPER-LEVEL BACK RESIDENT ROOM (not-occupied): -The carpet had multiple significant wrinkles creating potential tripping concerns. The LALD-C stated that they were in the process of replacing all carpets. -The toilet bowl was stained and had not been cleaned recently. -The toilet paper holder and shower bar were missing or had been removed. The LALD-C explained that the previous client grabbed on to those items while using the toilet. Survey staff explained to the LALD-C that if a resident was grabbing on to the shower bar and toilet paper holder for assistance while using the bathroom, they need to install accessible grab bars for the resident. 2) The lower-level back resident room (not-occupied) had carpet removed and in state of repair work. The LALD-C explained that the room was under remodeling and recarpeting. 3)The patio door in the lower level was extremely difficult to open. 4) The lower-level right resident room (occupied) had a wood stud sitting up inside corner of the window well. Survey staff explained to the LALD-C that the window well must be maintained free of all obstructions for safe egress during an emergency or fire. On June 22, 2022, approximately at 4:30 p.m., during the exit interview, the LALD-C acknowledged the findings.	0 800		

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0 800	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 800		
0 810 SS=E	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	0 810		

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0 810	Continued From page 14 drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of occupied 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 22, 2022, at approximately 2:50 p.m., survey staff received and reviewed the facility's fire safety and evacuation documentation, the evacuation drill, and the training documentation from the licensed assisted living director (LALD)-C. FIRE SAFETY AND EVACUATION PLAN The plan documentation lacked fire protection procedures for residents. FIRE AND EVACUATION DRILLS Documentation review indicated no fire and evacuation drill records were available for review. The LALD-C explained that the manager took the drill records with her when she went out of town. Survey staff agreed to receive additional	0 810		

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0 810	Continued From page 15 information on drill records for further review until the end of the next day (June 23, 2022). On June 22, 2022, approximately at 4:30 p.m., during the exit interview, the LALD-C acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all physical facility elements, including, the minimum size egress window openings for resident bedrooms, do not create a distinct hazard to residents and staff. This affected three occupied resident bedrooms on the main floor.	0 820		

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0 820	Continued From page 16 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: On June 22, 2022, approximately from 1:15 p.m. to 3:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. Survey staff measured the windows in the three bedrooms on the main level and explained to the LALD-C that the windows in the bedrooms did not meet the minimum size egress window openings required for safe egress. At least one window in each bedroom must meet the state standard minimum existing window opening size of at least 20 inches in width (and a minimum height of 20 inches) with a total of at least 648 square inches (4.5 square feet) required for egress window openings for bedrooms for assisted living facilities. The egress window opening dimensions in two bedrooms (one occupied and one unoccupied) on the main floor were measured with width of 13 inches and height of 36 inches, and the largest window in the third occupied bedroom (back of the main level) was measured at 18 inches in width and 48 inches in height. The LALD-C confirmed the findings. On June 22, 2022, at about 3:25 p.m., survey staff explained to the LALD-C that an immediate correction is issued for the above findings. The LALD-C acknowledged the findings. The LALD-C	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33372	A. BUILDING: _____ B. WING _____	06/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASSURED CARE	13404 KNOB HILL ROAD BURNSVILLE, MN 55337

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0 820	Continued From page 17 reached out to the owner via telephone and they inquired about options to remove the immediacy since window replacements required time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days On June 23, 2022, the immediacy of correciton order 0820 was removed, however, non-compliance remains at a level 3 widespread scope (I).	0 820		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider;	0 930		

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0 930	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with record reviewed. 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: R1 was admitted June 4, 2018, under the licensee's comprehensive license, and began receiving services under the assisted living license August 1, 2021. R1's record included an Assisted Living Contract signed August 1, 2021. The contract lacked: - the right under section 144G.54 to appeal the termination of an assisted living contract. On June 21, 2022, at 12:43 p.m., licensed assisted living director (LALD)-C acknowledged the current assisted living contract did not include a notice of the right to appeal termination of the contract. LALD-C verified all residents received the same contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01440	Continued From page 19	01440		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of two employees (unlicensed personnel (ULP)-B) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01440		

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01440	Continued From page 20 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). The findings include: ULP-B was hired November 25, 2019, and provided direct care and assistance with treatment and medication administration for the licensee's residents. ULP-B's employee record included competency evaluations dated December 2, 2019, for medication administration and treatment services, but lacked documentation of direct supervision of delegated tasks within 30 days of providing services. On June 22, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-C indicated the 30-day supervision for ULP-B might be located in a stack of papers taken by a consultant for organizing of employee files, but did not provide the documentation. The licensee's Supervision: Unlicensed Staff policy, dated April 7, 2022, indicated, "Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of two employees (registered nurse (RN)-A) with records reviewed. This had the potential to affect all three (3) residents.	01530		

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01530	Continued From page 22 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). The findings include: RN-A began employment on March 21, 2022, and provided supervisory and direct care services for the licensee. On June 21, 2022, at 11:00 a.m., during the entrance conference, RN-A indicated her regular working hours were Monday through Thursday from 9:00 a.m. to 5:00 p.m., as well as being on call on alternate weekends. RN-A's employee record included documentation of 6.25 hours of dementia care training completed. On June 22. 2022, at 8:57 a.m., RN-A stated all dementia care training was done through an online training system. RN-A further stated it was likely an oversight by the licensed assisted living director (LALD) when assigning the training. RN-A indicated the training would be completed immediately. The licensee's Dementia Education policy, dated April 7, 2022, indicated, "Supervisors of direct-care staff will have at least eight (8) hours of initial education within 120 working hours of employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias	01530		

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01530	Continued From page 23 b. Assistance with activities of daily living (ADL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-on (21) days	01530		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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	03090		

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03090	Continued From page 24 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 June 21, 2022, at 10:35 a.m., the surveyor observed signs posted at the entrance and in common areas of the facility with the words, "Security Camera In Use". No signage was observed with the required verbiage regarding electronic monitoring. On June 21, 2022, at 10:58 a.m., licensed assisted living director (LALD)-C verified no additional signage was present, and acknowledged the "security cameras" signage needed to include the verbiage required in the statute. Registered nurse (RN)-A indicated it was an oversight, and would be corrected immediately. The licensee's Electronic Monitoring policy dated April 7, 2022, indicated the licensee would post a sign at each facility entrance accessible to visitors indicating: 'Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities.'" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *06/21/22*
Time: 11:57:31
Report: 8075221123

Food and Beverage Establishment Inspection Report

Location:
Assured Care
13404 Knob Hill Road
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0033367
Risk: Low
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:
Nuline Solutions Inc.

Phone #: 9522903003
ID #: 47227

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.

Surface and Equipment Sanitizers

Chlorine: = 100ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: fridge - lasagna
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: fridge - deli meat
Violation Issued: No

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

Note: Facility prepares time/temperature control for safety food for same day service. In accordance with MN Rules, part 4626.0506, subpart G, facility is exempt from the equipment requirements of MN Rules, part 4626.0506, subpart A.

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 8075221123 of 06/21/22.

Certified Food Protection Manager: Tasheta F. Barnes

Certification Number: FM109715 Expires: 12/01/24

Signed: _____

Careese Coleman
CEO/ Assisted Living Director

Signed: Erin Tibbetts

Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
erin.tibbetts@state.mn.us