Electronically Delivered

December 22, 2022

Licensee
Cypress Manor
16770 Wren Street Northwest
Andover, MN 55304

RE: Project Number(s) SL25460015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on November 23, 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.

LICENSING ORDERS
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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.

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

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

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

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

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

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

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25460	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS MANOR	16770 WREN STREET NW ANDOVER, MN 55304

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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: SL25460015-0 On November 21, 2022, through November 23, 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 ten (10) residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2 and 3	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 21, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 650	Continued From page 2	0 650		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one	0 650		

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0 650	Continued From page 3 employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C began employment on November 15, 2021. ULP-C's employee record lacked the following: - documentation of an annual performance review that identified areas of improvement needed and training needs. On November 21, 2022, at 2:45 p.m., registered nurse (RN)-A stated they have not completed annual performance reviews. They have a new policy regarding annual performance reviews and will start completing them. RN-A further stated none of the staff have had a performance review completed. The licensee's Supervision of Nurses and Licensed Health Professionals policy dated June 6, 2022, indicated [the facility] will conduct annual performance evaluations for all nurses and other health professionals on staff. These evaluations shall be conducted by the Clinical Nurse Supervisor and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 650		

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0 650	Continued From page 4 (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors.	0 680		

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0 680	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On November 21, 2022, at 2:20 p.m., registered nurse (RN)-A stated the licensee had not completed appendix Z. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated June 6, 2022, indicated it is the intent that [the facility] has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z-Emergency Preparedness for All Provides and Certified Supplier Types: Interpretive Guidance." No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 6 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. 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 November 22, 2022, between 10:30 a.m. and 11:40 a.m., survey staff toured the facility with maintenance (M)-D. During the facility tour,	0 780		

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0 780	Continued From page 7 survey staff observed the following: 1. A smoke alarm was not installed in a basement resident sleeping room. M-D confirmed the findings during the facility tour interview. 2. When smoke alarms in resident rooms on the main floor were tested by M-D, none of the other alarms within the dwelling unit were activated. During the facility tour interview, M-D confirmed that smoke alarms were not interconnected so that actuation of one alarm caused all alarms in the dwelling unit to operate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 800		

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0 800	Continued From page 8 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 November 22, 2022, between 10:30 a.m. and 11:40 a.m., survey staff toured the facility with maintenance (M)-D. During the facility tour, survey staff observed the following: 1. Handles were not installed on egress windows in two resident sleeping rooms in the basement. The window handles were stored on the window sills in these resident rooms. The M-D installed the handles on the egress windows during the facility tour and then demonstrated that these windows were operational. 2. The battery-operated smoke alarms in two resident sleeping rooms on the main floor did not work when tested by M-D. The M-D made corrections to the smoke alarms so that the alarms then tested as operational during the facility tour. 3. A cover was not installed on an electrical outlet located on the wall in a resident room on the main floor. Covers were not installed on several electrical outlets and a light switch in the garage. 4. The last recorded testing date was 2018 for the reduced pressure zone device located in the mechanical room. The M-D confirmed the findings during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		

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

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0 810	Continued From page 10 training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 22, 2022, at 10:30 a.m., documents were provided for review. Documents were reviewed by survey staff on November 22, 2022, between 11:40 a.m. and 12:05 p.m. 1. The Whispering Pines plans for fire safety and evacuation were not developed for the facility location. 2. Smoke compartment doors, sprinklers, and fire doors on magnetic holders were referenced but not identified in the 7.05 Fire Policy dated 02/07/2020. 3. The plans did not include the identification of unique or unusual resident needs for movement or evacuation. 4. Documentation to support annual fire safety and evacuation training for residents was requested but not provided. 5. The licensee failed to meet the evacuation drill frequency requirements of twice per year per shift with at least one evacuation drill every other month. One completed evacuation drill log dated 10/1/2022 was provided but no additional logs or schedules were included in the documentation. On November 22, 2022, at approximately 12:10 p.m., the licensed practical nurse (LPN)-B	0 810		

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0 810	Continued From page 11 confirmed during an interview that the facility failed to provide the required content within the fire safety and evacuation plans. They also confirmed that the resident training and drill frequency requirements were not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must	01060		

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01060	Continued From page 12 be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 started receiving services on October 4, 2021. R1's service plan dated October 10, 2022, indicated R1 received assistance with activities of daily living, medication administration, treatments,	01060		

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	25460	A. BUILDING: _____ B. WING _____	11/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01060	Continued From page 13 housekeeping, and laundry. R1's record indicated the following hospitalizations: - R1 admitted to the hospital November 4, 2021, and returned November 10, 2021. - R1 admitted to the hospital January 5, 2022, and returned January 8, 2022. - R1 admitted to the hospital September 25, 2022, and returned on October 13, 2022. R1's record lacked a written notice including: - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. R1's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On November 22, 2022, at 1:25 p.m., registered nurse (RN)-A stated they did not give a written notice for emergency relocation or notify the Ombudsman. RN-A stated she was not aware of the requirement and none of the residents who had been to the hospital received the notice.	01060		

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01060	Continued From page 14 The licensee's Emergency Relocation policy dated June 6, 2022, indicated in the event of an emergency relocation, [the facility] will provide a written notice that contains, at a minimum the above required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=F	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	01440		

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01440	Continued From page 15 by: Based on observation, 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 one employee (unlicensed personnel (ULP)-C). 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: ULP-C had a hire date of November 15, 2021. ULP-C's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On November 21, 2022, at 12:00 p.m., the surveyor observed ULP-C performing medication administration for R1. On November 21, 2022, at 2:45 p.m., RN-A stated they have not completed any 30-day supervisions for ULP-C or for any staff. RN-A stated she was not aware of the requirement. The licensee's Supervision of Staff-Delegated Services policy dated June 6, 2022, indicated direct supervision of staff performing delegated	01440		

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01440	Continued From page 16 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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01470	Continued From page 17 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for one of one employee (unlicensed personnel (ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

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01470	Continued From page 18 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C was hired on November 15, 2021, to provide direct care services to residents at the assisted living facility. On November 21, 2022, at 12:00 p.m., the surveyor observed ULP-C administer R1's scheduled medications. ULP-C's employee records lacked the following required orientation content: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On November 21, 2022, registered nurse (RN)-A stated ULP-C was not trained on person-centered care upon hire but did get it at her annual training. RN-A further stated no staff was trained on person-centered care upon hire. The licensee's Orientation of Staff and Supervisors & Content policy dated June 6, 2022, indicated all staff of [the facility] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must contain the following topics: principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01470		

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01470	Continued From page 19 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	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 observation, interview, and record	01530		

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01530	Continued From page 20 review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C was hired on November 15, 2021, to provide services to the licensee's residents. On November 21, 2022, at 12:00 p.m., the surveyor observed ULP-C administer medications to R1. ULP-C's orientation and training record lacked documentation of the required number of hours of dementia training. ULP-C's training record included: 1. Caring for someone with Early to Mid-Alzheimer's Disease (DVD) (45 minutes) 2. Caring for someone with Mid-Late Alzheimer's Disease (DVD) (65 minutes) 3. Behaviors with Alzheimer's (book) (30 minutes) 4. Caregivers Guide for Alzheimer's Disease (book) (60 minutes) On November 21, 2022, at 2:45 p.m., registered nurse (RN)-A stated upon hire, ULP-C only received four hours of dementia training. RN-A further stated she thought that was all they needed since the facility is not a dementia unit	01530		

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01530	Continued From page 21 and the same amount of training would apply for all staff. The licensee's Dementia Training policy dated June 6, 2022, indicated all staff of [the facility] are required to complete dementia training at the time of hire and annually thereafter. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620		

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01620	Continued From page 22 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 ensure the registered nurse (RN) completed a reassessment not to exceed 14 days for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The findings include: R1 had an admission date of October 4, 2021, with a diagnosis of quadriparesis (weakness in all four limbs). R1's service plan dated October 10, 2022, indicated R1 received services including medication management, assistance with activities of daily living, colostomy care, and catheter care. R1's 14-day assessment was completed on October 28, 2021, 24 days after his initiation of services. On November 22, 2022, RN-A stated she was not	01620		

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01620	Continued From page 23 sure why that assessment was late, she knows assessments need to be completed within 14 days and they normally are. The licensee's Assessments, Reviews & Monitoring policy dated June 6, 2022, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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 entryway of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a	03090		

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03090	Continued From page 24 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 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The finding include: On November 21, 2022, at 2:00 p.m., the surveyor observed the signage posted regarding electronic monitoring lacked the required verbiage. The sign posted outside the front door stated, "camera surveillance is on in the common areas of this house." On November 21, 2022, at 3:00 p.m., registered nurse (RN)-A stated she was not aware the electronic monitoring sign had to be exact verbiage. The licensee's Electronic Monitoring policy dated June 6, 2022, indicated signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *11/21/22*
Time: 12:30:22
Report: 1029221382

Food and Beverage Establishment Inspection Report

Location:
Cypress Manor
16770 Wren Street Nw
Andover, MN55304
Anoka County, 02

Establishment Info:
ID #: 0039327
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637128363
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

No evidence of employee illness log. Employee illness log emailed to Amber following the inspection.

Comply By: 11/23/22

3-500B Microbial Control: hot and cold holding

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

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

Multiple items in the upstairs and downstairs refrigerators measured above 41°F. Elevated temperatures were not due to preparation or delivery and appeared to be caused by circulation or settings issues with the refrigeration devices. Items discarded.

Comply By: 11/21/22

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

Establishment not using heat or chemicals to sanitize food contact surfaces. Instructed Amber to provide sanitizing dishwasher or use chemical agent, such as chlorine bleach, to sanitize.

Comply By: 11/21/22

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Small diameter probe thermometer not present at establishment. Instructed Amber to obtain a small diameter thermometer.

Comply By: 12/02/22

Food and Equipment Temperatures

Process/Item: butter
Temperature: 51 Degrees Fahrenheit - Location: downstairs refrigerator door
Violation Issued: Yes

Process/Item: butter
Temperature: 60 Degrees Fahrenheit - Location: downstairs refrigerator door
Violation Issued: Yes

Process/Item: shredded cheese
Temperature: 40 Degrees Fahrenheit - Location: downstairs refrigerator back interior
Violation Issued: No

Process/Item: shredded cheese
Temperature: 48 Degrees Fahrenheit - Location: downstairs refrigerator front interior
Violation Issued: Yes

Process/Item: milk
Temperature: 46 Degrees Fahrenheit - Location: downstairs refrigerator door
Violation Issued: Yes

Process/Item: lactaid
Temperature: 46 Degrees Fahrenheit - Location: downstairs refrigerator
Violation Issued: Yes

Process/Item: milk
Temperature: 48 Degrees Fahrenheit - Location: downstairs refrigerator
Violation Issued: Yes

Process/Item: milk
Temperature: 46 Degrees Fahrenheit - Location: upstairs refrigerator
Violation Issued: Yes

Process/Item: lactaid
Temperature: 39 Degrees Fahrenheit - Location: upstairs refrigerator back interior
Violation Issued: No

Process/Item: silk soy milk
Temperature: 47 Degrees Fahrenheit - Location: upstairs refrigerator
Violation Issued: Yes

Food and Beverage Establishment Inspection Report

Process/Item: silk soy milk
Temperature: 44 Degrees Fahrenheit - Location: upstairs refrigerator
Violation Issued: Yes

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

This inspection was conducted in conjunction with an HRD survey at Cypress Manor (Whispering Pines Assisted Living, INC.), located at 16770 Wren Street, Andover, MN 55304 in the county of Anoka.

The inspection was conducted partially or entirely in the presence of Amber Lynch, LPN; Darwin Gangl, Nursing Assistant; and other staff. All issues were discussed with Amber during and after the inspection. Employee illness reporting and exclusion procedures were also discussed in addition to general food safety practices. All issues were communicated to lead HRD surveyor and HFE-Nursing Evaluator II, Wendy Robarge, MSN, PHN, following the inspection.

The facility has an upstairs and downstairs kitchen. Most of the food preparation occurs in the downstairs kitchen. Downstairs kitchen has tile flooring, laminate countertops, smooth painted walls, wood cabinetry and drawers with paper laminate interior surface coverings, and a slightly textured ceiling with minor cracking. Upstairs kitchen has tile flooring, stone countertops, smooth painted walls, wood cabinetry with smooth laminate interiors, and a highly textured popcorn ceiling. Excluding minor wearing, the kitchens are in good condition.

The importance of adequate cold holding, and sanitizing was emphasized. The downstairs Frigidaire dishwasher and the upstairs Amana dishwasher did not have sanitizer settings, nor did they bear the NSF/ANSI 184 for residential dishwashers. Establishment did not have means to sanitize. Instructed Amber to sanitize food contact surfaces with a chemical sanitizer until they are able to provide a dishwasher that sanitizes to the NSF/ANSI 184 standard. I instructed Amber to sanitize using a chemical solution, such as chlorine bleach, quaternary ammonium, iodine, lactic acid or any other sanitizer that is approved by the EPA to sanitize food contact surfaces. I also instructed Amber to obtain matching test strips for the selected sanitizer. I instructed Amber to never mix chemicals.

Multiple TCS items in the upstairs and downstairs refrigerators were observed to be above 41°F. The temperature abuse did not appear to be a result of food preparation or delivery, but rather caused by mechanical, or circulation issues. All TCS items that were identified to have been subjected to temperature abuse were discarded, and both refrigerators were adjusted to maintain foods at 41°F or below.

Employee illness log, and food safety information was emailed to Amber following the inspection.

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 1029221382 of 11/21/22.

Certified Food Protection Manager Nicole Lynn Aldes

Certification Number: FM107381 Expires: 06/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Amber Lynch
LPN

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029221382

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	3	Date	11/21/22
No. of Repeat RF/PHI Categories Out	0	Time In	12:30:22
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Cypress Manor	16770 Wren Street Nw	Andover, MN	55304	7637128363

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039327		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

	Compliance Status					Compliance Status	COS	R
	Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight			
2	(IN)	OUT	N/A		Certified food protection manager, duties			
	Employee Health							
3	IN	(OUT)			Mgmt/Staff;knowledge,responsibilities&reporting			
4	(IN)	OUT			Proper use of reporting, restriction & exclusion			
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events			
	Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use			
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth			
	Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed			
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible			
	Approved Source							
11	(IN)	OUT			Food obtained from approved source			
12	IN	OUT	N/A	(N/O)	Food received at proper temperature			
13	(IN)	OUT			Food in good condition, safe, & unadulterated			
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction			
	Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected			
16	IN	(OUT)	N/A		Food contact surfaces: cleaned & sanitized			
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food			
						Time/Temperature Control for Safety		
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature			
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding			
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature			
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures			
22	IN	(OUT)	N/A		Proper cold holding temperatures			
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition			
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records			
						Consumer Advisory		
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food			
						Highly Susceptible Populations		
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered			
						Food and Color Additives and Toxic Substances		
27	IN	OUT	(N/A)		Food additives: approved & properly used			
28	(IN)	OUT			Toxic substances properly identified, stored, & used			
						Conformance with Approved Procedures		
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP			

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

GOOD RETAIL PRACTICES

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

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

			COS	R				COS	R
		Safe Food and Water					**Proper Use of Utensils**		
30	IN OUT (N/A)	Pasteurized eggs used where required			43		In-use utensils: properly stored		
31		Water & ice obtained from an approved source			44		Utensils, equipment & linens: properly stored, dried, & handled		
32	IN OUT (N/A)	Variance obtained for specialized processing methods			45		Single-use/single service articles: properly stored & used		
		Food Temperature Control			46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control					**Utensil Equipment and Vending**		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding			47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	IN OUT N/A (N/O)	Approved thawing methods used			48		Warewashing facilities: installed, maintained, & used; test strips		
36	X	Thermometers provided & accurate			49		Non-food contact surfaces clean		
		Food Identification					**Physical Facilities**		
37		Food properly labled; original container			50		Hot & cold water available; adequate pressure		
		Prevention of Food Contamination			51		Plumbing installed; proper backflow devices		
38		Insects, rodents, & animals not present			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage & display			53		Toilet facilities: properly constructed, supplied, & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained, & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
					57		Compliance with MCIAA		
					58		Compliance with licensing & plan review		

Food Recalls: _____

Person in Charge (Signature) **Date:** 11/23/22

Inspector (Signature)