DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 23, 2023

Licensee
Parmly On The Lake
28210 Old Towne Road
Chisago City, MN 55013

RE: Project Number(s) SL20872015

Dear Licensee:

On February 27, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 14, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

Electronically Delivered

January 5, 2023

Licensee
Parmly on the Lake
28210 Old Towne Road
Chisago City, MN 55013

RE: Project Number(s) SL20872015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 14, 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 . . ."

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 - 1420 - 144g.62 Subd. 2 - Delegation Of Assisted Living Services - $3,000.00
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00
St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - $3,000.00

The total amount you are assessed is $9,000.00. 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 reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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,

Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20872	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20872015 On December 12, 2022, through December 14, 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 49 active residents receiving services under the Assisted Living with Dementia Care license. Immediate correction orders were identified on December 13, 2022, issued for SL20872015, tag identifications 1420, 1750, and 1950. On December 14, 2022, immediacy of correction orders 1420, 1750, and 1950 was removed, however, non-compliance remains at a scope and level of G, H and G, respectively.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 12, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-C and registered	0 250		

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0 250	Continued From page 3	0 250		

nurse (RN)-A stated the leadership team in charge of the facility were familiar with the assisted living regulations and the licensee provides assistance with activities of daily living (ADL's), medication and treatment management services, and housekeeping.

The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]:

- I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.

- I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable.

- Assisted Living Licensure statutes in Minn. Stat. chpt. 144G.

- Assisted Living Licensure rules in Minnesota Rules, chpt. 4659.

- Reporting of Maltreatment of Vulnerable Adults.

- Electronic Monitoring in Certain Facilities.

- I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will

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0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorized agent (AA)-I on May 18, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of July 31, 2023. The licensee failed to ensure the following policies and procedures were implemented: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) handling complaints regarding staff or services provided by staff; (4) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (5) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other	0 250		

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0 250	Continued From page 6 health care providers as appropriate; (6) infection control practices; (7) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (8) medication and treatment management; and (9) delegation of tasks by registered nurses or licensed health professionals. As a result of this survey, the following orders were issued 0480, 0510, 0630, 0640, 0660, 0680, 0770, 0930, 0950, 1060, 1370, 1380, 1420, 1540, 1620, 1640, 1650, 1750, 1760, 1790, 1880, 1890, 1950, 2040, 2410, and 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 7 (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 December 12, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	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	0 510		

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0 510	Continued From page 8 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, interview and record review, the licensee failed to ensure infection control standards were followed for one of one resident (R2) with oxygen therapy. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included type two diabetes, heart failure, shortness of breath, and respiratory failure. R2's service plan dated December 12, 2022, indicated R2 received the following services: medication management, blood glucose monitoring, oxygen therapy management, bathing, dressing, grooming, toileting, housekeeping, and laundry.	0 510		

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0 510	Continued From page 9 On December 13, 2022, at 9:57 a.m., the surveyor observed unlicensed personnel (ULP)-G enter R2's room and administer R2 her morning scheduled medications. On the way out of R2's room, the surveyor observed R2's nasal cannula oxygen tubing from portable oxygen was laying directly on the floor. ULP-G picked up R2's nasal cannula off the floor and without disinfecting the nasal cannula or replacing the oxygen tubing, ULP-G placed it back onto R2's wheelchair for later use. On December 14, 2022, at 12:02 p.m., registered nurse (RN)-A stated R2's oxygen tubing should have been replaced if it was found lying on the floor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for four of four residents (R1, R2, R3, R4). 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: R1 R1's diagnoses included Alzheimer's disease, Parkinson's disease (a progressive disorder that affects the nervous system), and type two diabetes. R1's service plan dated March 9, 2022, indicated R1 received the following services: medication management, dressing, grooming, transferring, toileting, and housekeeping. R1's Individual Abuse Prevention Plan dated March 8, 2022, lacked an individual review or assessment of R1's susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the risk of abuse. R2 R2's diagnoses included type two diabetes, and	0 630		

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	20872	A. BUILDING: _____ B. WING _____	12/14/2022

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0 630	Continued From page 11 heart failure. R2's service plan dated December 12, 2022, indicated R2 received the following services: medication management, blood glucose monitoring, bathing, dressing, grooming, toileting, housekeeping, and laundry. R2's Individual Abuse Prevention Plan dated March 21, 2022, lacked an individual review or assessment of R2's susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the risk of abuse. R3 R3's diagnoses included fractured sacrum. R3's service plan dated October 18, 2022, indicated R3 received the following services: medication management, bathing, dressing, housekeeping and laundry. R3's Individual Abuse Prevention Plan dated June 23, 2022, lacked an individual review or assessment of R3's susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the risk of abuse. R4 R4's diagnoses included COPD (chronic obstructive pulmonary disease). R4's service plan dated October 18, 2022, indicated R4 received the following services: medication management, bathing, dressing, grooming, transfers, toileting, laundry, and	0 630		

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0 630	Continued From page 12 housekeeping. R4's Individual Abuse Prevention Plan dated March 15, 2022, lacked an individual review or assessment of R4's, susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the risk of abuse. On December 14, 2022, at 10:30 a.m. registered nurse (RN)-A stated R1, R2, R3, and R4's and all other residents Individual Abuse Prevention Plans did not include susceptibility to abuse by another individual, including other vulnerable adult, susceptibility self-abuse and statements of the specific measures to be taken to minimize the risk of abuse. The licensee's Vulnerable Adult Reporting - Assisted Living Licensure policy revised August 1, 2021, indicated residents with services are assessed through the pre-admission medical screening process for susceptibility to abuse by individuals and their risk of abusing others. This assessment included risk of self-abuse. Plans are developed and measure taken to minimize risks. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640		

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0 640	Continued From page 13 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557 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 December 12, 2022, at 2:53 p.m., the surveyor toured the facility with licensed practical nurse (LPN)-B noting the main entrances and/or common areas lacked the required posting of the reporting number for MAARC to report suspected maltreatment of the vulnerable adult under section 626.557. On December 12, 2022, at 2:53 p.m., LPN-B stated the contact information for MAARC were	0 640		

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0 640	Continued From page 14 not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure TB history, symptom screen, and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of five employees (registered nurse (RN)-A).	0 660		

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0 660	Continued From page 15 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: The licensee's TB Risk Assessment, dated October 18, 2022, indicated the facility was a low risk. RN-A began providing supervision of employees and residents in October 2022, under the licensee's assisted living with dementia care license. Throughout the survey, RN-A was observed to supervise employees. RN-A's employee record lacked evidence TB history, symptom screen, and TST had been completed. On December 13, 2022, at 2:00 p.m., RN-A stated RN-A's employee record lacked evidence TB history, symptom screen, and TST had been completed. The licensee's Tuberculosis and Staff Screening policy dated January 2020, indicated staff of [facility name] whose essential job functions require work within the same air space of home care clients shall be screened and tested for tuberculosis prior to the staff being exposed to clients.	0 660		

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0 660	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 680		

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0 680	Continued From page 17 review the licensee failed to ensure the emergency disaster plan was posted prominently. 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 December 12, 2022, at 2:53 p.m., the surveyor toured the facility with licensed practical nurse (LPN)-B noting the main entrances and/or common areas lacked the required posting of the of the emergency disaster plan in a prominent area. On December 14, 2022, at 10:30 a.m. the licensed assisted living director (LALD)-C confirmed the emergency disaster plan was not posted in a prominent location. On December 14, 2022, at 12:02 p.m., registered nurse (RN)-A confirmed the emergency disaster manuals were stored in the cupboard on each unit in the caregiver's office. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements	0 770		

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0 770	Continued From page 18 The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain an all-weather walk. 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 December 12, 2022, between 12:15 p.m. and 1:40 p.m., survey staff toured the facility with the maintenance director (MD)-I and regional maintenance (RM)-J. During the facility tour, survey staff observed that the all-weather walk was covered in snow outside the marked exit	0 770		

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0 770	Continued From page 19 near room 123 in the Vindauga building. The MD-I and RM-J confirmed the findings during the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 770		
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: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for four of four residents (R1, R2, R3, R4). This had the potential to affect all 49 residents.	0 930		

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0 930	Continued From page 20 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 the potential to affect a large portion or all the residents). The findings include: R1 R1's diagnoses included Alzheimer's disease, Parkinson's disease (a progressive disorder that affects the nervous system), hearing loss, and type two diabetes. R1's service plan dated March 9, 2022, indicated R1 received the following services: medication management, dressing, grooming, transferring, escort to all meals, reassurance checks four times a day, toileting, and housekeeping. R2 R2's diagnoses included type two diabetes, and heart failure. R2's service plan dated December 12, 2022, indicated R2 received the following services: medication management, blood glucose monitoring, bathing, dressing, grooming, toileting, oxygen management, housekeeping, and laundry. R3 R3's diagnoses included fractured sacrum. R3's service plan dated October 18, 2022, indicated R3 received the following services:	0 930		

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0 930	Continued From page 21 medication management, bathing, dressing, housekeeping and laundry. R4 R4's diagnoses included COPD (chronic obstructive pulmonary disease). R4's service plan dated October 18, 2022, indicated R4 received the following services: medication management, bathing, dressing, grooming, transfers, toileting, laundry, and housekeeping. R1, R2, R3, and R4's Assisted Living Contract dated March 7, 2022, September 7, 2021, August 9, 2021, and August 10, 2021, respectively, lacked the following: -contact information of the person representing the facility who is designated to handle and resolve complaints. On December 12, 2022, at 1:40 p.m., registered nurse (RN)-B stated the Assisted Living Contract provided to R1, R2, R3, R4, and all other residents receiving services under the licensee's Assisted Living with Dementia Care license, did not include the contact information of the person representing the facility who is designated to handle and resolve complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 950 SS=C	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950		

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0 950	Continued From page 22 must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer two of two residents (R3, R4) the opportunity to decline a designated representative. This had the potential to affect all 49 residents. 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	0 950		

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0 950	Continued From page 23 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: R3 R3's diagnoses included fractured sacrum. R3's service plan dated October 18, 2022, indicated R3 received the following services: medication management, bathing, dressing, housekeeping and laundry. R4 R4's diagnoses included COPD (chronic obstructive pulmonary disease). R4's service plan dated October 18, 2022, indicated R4 received the following services: medication management, bathing, dressing, grooming, transfers, toileting, laundry, and housekeeping. R3 and R4's records lacked evidence the notice with the required statutory language for the resident to identify a designated representative, allowed R2 and R4 the opportunity to decline to name a designated representative. On December 12, 2022, at 1:40 p.m., registered nurse (RN)-A stated the Assisted Living contract provided to R3, R4, and all other residents receiving services under the licensee's Assisted Living with Dementia Care license, lacked the opportunity for the resident to decline to name a designated representative.	0 950		

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0 950	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01060 SS=D	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 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	01060		

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(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
01060	Continued From page 25 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, licensee failed to provide written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's progress notes indicated the following: -September 12, 2022, at 2:31 p.m., when R4 was on the gurney from the ambulance, she asked the EMT's (emergency medical technician) for a drink of water because her mouth was dry. After she was done drinking some water she had asked for something to cover her mouth with. She wanted something to cover her mouth in case she vomited. -September 13, 2022, at 1:44 p.m., the social	01060		

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	20872	A. BUILDING: _____ B. WING _____	12/14/2022

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01060	Continued From page 26 worker from the hospital, stated R4 was admitted for small bowel obstruction and aspiration pneumonia. R4 was on three (3) liter of oxygen. Therapy recommended a referral to a TCU (transitional care unit) as R4 is weaker. -October 12, 2022, at 1:02 p.m., R4 was admitted to the TCU. Medications were reviewed by the RN (registered nurse) and LPN (licensed practical nurse). Services updated and addendum signed. The licensee lacked documentation providing a reason for the relocation, and a written notice providing the required minimums: -reason for relocation; -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 or dates within which the resident is expected to return or a statement the return date is unknown; -a statement if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144.54. The facility must provide contact information for the agency to which the resident may submit an appeal; -the notice must be delivered as soon as practicable to: -the resident, legal representative, and designated representative; -for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and -the Office of Ombudsman for Long-Term Care if the resident has been relocated.	01060		

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01060	Continued From page 27 On December 14, 2022, at 10:30 a.m., RN-A stated R4 was not provided written notice with required content for an emergency relocation and the OOLTC was not notified of the emergency relocation. The licensee's emergency relocation policy dated August 1, 2021, indicated 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. The notice required under paragraph (b) must 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.	01060		

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01060	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences,	01370		

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01370	Continued From page 29 cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. 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 the required competency evaluations for one of four employees (unlicensed personnel (ULP)-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on October 4, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R4's December 2022, medication administration record (MAR) indicated ULP-E administered R4's scheduled evening medications on December 5, 2022, and R4's scheduled morning medications December 10 and 11, 2022.	01370		

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01370	Continued From page 30 ULP-E's employee record indicated licensed practical nurse (LPN)-B completed the following competency evaluations training: -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On December 13, 2022, at 3:01 p.m., RN-A confirmed LPN-B performed training and competency evaluations for ULP-E. RN-A stated LPN-B had received "Train the Trainer" training and then RN-A delegated training to LPN-B. RN-A stated I "comp" her off on the Assisted Living Overview, PCA (personnel care attendant) training document as you have seen per what our staff have and then all medication administration specific competencies. We go through return demo's [demonstrations], just as we do for staff. The licensee's Training and Competency Evaluations for Unlicensed Personnel policy dated November 2019, a RN or other licensed health professional where appropriate will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel. The training and competency evaluations of ULP's will be conducted by a RN or another instructor may provide the training in conjunction with a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. 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 the required competency evaluations for one of four employees (unlicensed personnel (ULP)-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01380		

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01380	Continued From page 32 ULP-E was hired on October 4, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R4's December 2022 medication administration record (MAR) indicated ULP-E administered R4's scheduled evening medications on December 5, 2022, and R4's scheduled morning medications December 10 and 11, 2022. ULP-E's employee record indicated licensed practical nurse (LPN)-B completed the following competency evaluations training: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. On December 13, 2022, at 3:01 p.m., RN-A confirmed LPN-B performed training and competency evaluations for ULP-E. RN-A stated LPN-B had received "Train the Trainer" training and then RN-A delegated training to LPN-B. RN-A stated I "comp" her off on the Assisted Living Overview, PCA (personnel care attendant) training document as you have seen per what our staff have and then all medication administration specific competencies. We go through return demo's [demonstrations], just as we do for staff. The licensee's Training and Competency Evaluations for Unlicensed Personnel policy dated November 2019, a RN or other licensed health professional where appropriate will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel. The training and	01380		

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01380	Continued From page 33 competency evaluations of ULP's will be conducted by a RN or another instructor may provide the training in conjunction with a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01420 SS=G	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP)-F who was observed using a sit-to stand mechanical lift. This practice resulted in a level three violation (a	01420		

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01420	Continued From page 34 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 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). This resulted in an immediate order on December 13, 2022. The findings include: ULP-F was hired on November 25, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On December 13, 2022, at 7:02 a.m., the surveyor entered R2's room and observed ULP-F transfer R2 with the sit to stand onto the side of R2's bed. ULP-F removed the sit-to stand sling and device and stated she needed assistance from staff to assist in transferring R2's into the Broda chair because she was new and was still in training. ULP-G entered R2's room and transferred R2 from the bed into the Broda chair while ULP-F observed the transfer. ULP- F's training record lacked evidence ULP-F had been trained by the RN and demonstrated competency in transferring with the use of the sit-to-stand mechanical lift. On December 13, 2022, at 3:02 p.m., RN-A confirmed LPN-B had trained ULP-F in the use of the sit-to-stand and ULP-F had demonstrated competency to LPN-B. RN-A stated LPN-B had received "Train the Trainer" training and then RN-A delegated medication administration	01420		

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01420	Continued From page 35 training to LPN-B. RN-A stated I "comp" her off on the Assisted Living Overview, PCA (personnel care attendant) training document as you have seen per what our staff have and then all medication administration specific competencies. We go through return demo's, just as we do for staff. The licensee's Training and Competency Evaluation for Unlicensed Personnel policy dated November 2019, indicated when a registered nurse or licensed health professional delegates tasks, they must make certain that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On December 14, 2022, immediacy was removed, however, non-compliance remains at an isolated scope, level three (G). TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not	01540		

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01540	Continued From page 36	01540		

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 review, the licensee failed to ensure one of four employees (unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

ULP-D was hired on January 21, 2022, to provide direct care for the licensee's residents.

On December 13, 2022, at 7:14 a.m., the surveyor observed ULP-D administer R4's scheduled morning medications.

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01540	Continued From page 37 ULP-D's employee records did not indicate a total of 8 hours of the required dementia training was completed within 80 hours of the employee's start date. On December 14, 2022, at 10:30 a.m., registered nurse (RN)-A stated ULP-D had not completed the required dementia training. The licensee's Training requirement for Assisted Living with Dementia Care policy (undated) indicated: [facility name] Assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training within 80 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 or a supervisor is 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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01620	Continued From page 38	01620		

reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment after a change of condition for three of three residents (R1, R2, R4), and licensee failed to ensure the RN completed ongoing resident assessments not to exceed 90 days for two of four residents (R1, R2).

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

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(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
01620	Continued From page 39 of the residents). The findings include: CHANGE OF CONDITION R1 R1's diagnoses included Alzheimer's disease, Parkinson's disease (a progressive disorder that affects the nervous system), hearing loss, and type two diabetes. R1's service plan dated March 9, 2022, indicated R1 received the following services: medication management, dressing, grooming, transferring, escort to all meals, reassurance checks four times a day, toileting, and housekeeping. R1's record indicated the following Resident Incident Reports were completed post falls and follow up was completed by the licensed practical nurse (LPN) on October 10, 11, 18, 22, 23, 2022, and November 2, 6, 8, 16, 24, 26, and 28, 2022. R1's record lacked documentation to indicate the RN reassessed R1 after the falls to include casual factors and develop interventions to reduce further falls. On December 14, 2022, at 11:38 a.m., RN-A provided the surveyor with R1's Fall Risk Assessment Tool completed on November 29, 2022, by the RN. On December 14, 2022, at 12:28 p.m., RN-A stated Resident Incident Reports were completed by whoever witnessed the incident and were a collection of data from staff and not considered an assessment. RN-A stated the Fall Risk Assessment Tool was completed by the RN if determined there was a pattern or a frequency of	01620		

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	20872	A. BUILDING: _____ B. WING _____	12/14/2022

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01620	Continued From page 40 falls. RN-A stated R1 had a history of falls and should have had a Fall Risk Assessment completed by the RN prior to November 29, 2022. R2 R2's diagnoses included type two diabetes, and heart failure. R2's most recent comprehensive assessment dated October 3, 2022, indicated R2 was independent with dressing, grooming, toileting and transferring. R2's service plan dated December 12, 2022, indicated R2 received the following services: medication management, blood glucose monitoring, bathing, dressing, grooming, toileting, oxygen management, housekeeping, and laundry. R2's record lacked a change in condition assessment following R2's increase of care needs and services. R2's progress notes indicated the following: -On December 2, 2022, LPN-B spoke with R2's daughter and informed of R2's increase of incontinence, refusal of cares, and proposed R2 move to Isabella House to better manage R2's increase in care needs. -On December 4, 2022, R2 moved to Isabella House and additional services were added to include an increase in toileting assistance. R2's daughter agreed to the move with the increase in services and planned to return the new service agreement the week of December 12, 2022. On December 14, 2022, at 12:20 p.m., RN-A confirmed R2's last assessment completed October 3, 2022, indicated R2 was independent	01620		

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01620	Continued From page 41 with dressing, grooming, toileting, and transferring and R2 should have had a change in condition assessment to reflect R2's current needs and services. R4 R4's diagnoses included COPD (chronic obstructive pulmonary disease) and muscle weakness. R4's service plan dated October 18, 2022, indicated R4 received the following services: medication management, bathing, dressing, grooming, transfers, toileting, laundry, and housekeeping. R4's Fall Risk Assessment Tool dated September 9, 2022, indicated the following: -gait impaired. R4 has difficulty rising from chair, uses chair arms to get up, bounces to rise, keeps head down when walking, watches the ground, grasps furniture, person or aid when ambulating, cannot walk unassisted. -overestimated or forgets limits; and -uses walker, wheelchair, gait disturbance/unsteady gait. R4's total score is 75 points. Resident with a score higher than 45 is a high risk for falls. R4's RN Assessment dated October 12, 2022, (completed by RN) indicated R4 required hands on assistance of one with toileting and transferring. The assessment did not address R4's history of falls. R4's RN 90-day assessment dated October 18, 2022, indicated R4's last reported fall was on September 9, 2022. R4's record indicated the following Resident	01620		

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01620	Continued From page 42 Incident Reports were completed post falls and follow up was completed by the LPN on October 20, and 26, 2022, November 11, 16, 26, and 27, 2022, and December 2, 2022. R4's Incident reports from October 20, 2022, to December 2, 2022, indicated R4 had eight (8) unwitnessed falls, with the following interventions used repeatedly: resident education, articles of need within easy reach, call cord or other device within easy reach, proper use of assistive devices, reeducation on safety, therapy evaluate and treat, continue with therapy, and follow therapy recommendations. R4's record lacked documentation to indicate the RN reassessed R4 after the falls to include casual factors and develop new interventions to reduce further falls. On December 14, 2022, at 10:30 a.m., RN-A stated the LPN collects data pertaining to the fall and goes over the data with the RN. RN-A stated the RN does the fall risk assessment. RN-A provided the surveyor with a Fall Risk Assessment that was completed on September 9, 2022. ONGOING ASSESSMENTS R1 R1's record indicated the RN completed a change in condition assessment on April 11, 2022, and a 90-day Monitoring and Reassessment on September 1, 2022, which exceeded 90 days from the previous completed assessment. (143 days between assessments). R2 R2's record indicated the RN completed a 90-day Monitoring and Reassessment on March 21,	01620		

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01620	Continued From page 43 2022, and September 8, 2022, which exceeded 90 days from the previous completed assessment. (171 days between assessments). On December 14, 2022, at 12:02 p.m., RN-A confirmed R1 and R2's 90-day assessments had not been completed within the required time frame. The licensee's Assessments-Schedule policy dated December 2019, indicated the following: -All assessments are completed utilizing individualized review specific for each resident. RN initial and subsequent assessments (14-day, 90-day and post hospitalization) must review most recent past RN assessment utilizing uniform assessment format; if noting any deviation or change since last assessment, RN conducting assessment must complete RN assessment format. If no deviations are noted upon review of most recent uniform assessment, RN may utilize 14-day/90-day format indicating specially that the RN has reviewed/assessed resident at the most recent RN uniform assessment tool and no deviations are noted. -Fall Assessments are completed after falls with injury, by the RN/LPN. The assessment is face-to-face with the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 44 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the licensee and resident and/or resident's representative to document agreement on the services to be provided for one of four residents (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01640		

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01640	Continued From page 45 situation has occurred only occasionally). The findings include: R1's service plans dated March 22, 2022, and December 12, 2022, did not include a signature or other authentication by the licensee or resident and/or resident's representative documenting agreement on the services provided. On December 13, 2022, at 7:14 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R1's scheduled morning medications. On December 13, 2022, at 3:49 p.m., registered nurse (RN)-A verified R1 had an increase of services on November 29, 2022, to include an increase in hourly reassurance checks and R1's service agreement/addendum had not been signed by the licensee or resident and/or resident's representative to authenticate the service plan. The licensee's Service Plan Modification policy dated November 2019, indicated a new Service plan will include the date and signature of tenant or the tenant's representative each time a modification is made. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650		

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01650	Continued From page 46 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plans included the required content for four of four residents (R1, R2, R3, R4). 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	01650		

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01650	Continued From page 47 or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's service plan dated March 9, 2022, indicated R1 received the following services: medication management, dressing, grooming, transferring, toileting, and housekeeping. On December 13, 2022, at 7:14 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R1's scheduled morning medications. R2 R2's service plan dated December 12, 2022, indicated R2 received the following services: medication management, blood glucose monitoring, bathing, dressing, grooming, toileting, housekeeping, and laundry On December 13, 2022, at 9:42 a.m., the surveyor observed ULP-G administer R2's scheduled morning medications. R3 R3's service plan dated October 18, 2022, indicated R3 received the following services: medication management, bathing, dressing, housekeeping and laundry. On December 13, 2022, at 9:00 a.m., the surveyor observed ULP-H administer R3's scheduled morning medications. R4 R4's service plan dated October 18, 2022, indicated R4 received the following services: medication management, bathing, dressing,	01650		

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01650	Continued From page 48 grooming, transfers, toileting, laundry, and housekeeping. On December 13, 2022, at 7:14 a.m., the surveyor observed ULP-D administer R4's scheduled morning medications. R1, R2, R3 and R4's service plans lacked the following required content: -the schedule and method of monitoring staff providing services. On December 14, 2022, at 10:30 a.m. registered nurse (RN)-A stated R3, R4, and all other residents' services plans did not include the schedule and method of monitoring staff providing services. The licensee's Service Plan policy revised August 1, 2021, indicated the service plan must include the following elements: -the frequency of sessions of sessions of supervision of staff and type of personnel who will supervise staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days On December 14, 2022, immediacy was removed, however, non-compliance remains at a pattern scope, level three (H). TIME PERIOD FOR CORRECTION: Seven (7) days	01650		
01750 SS=H	144G.71 Subd. 7 Delegation of medication administration	01750		

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01750	Continued From page 49 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of four unlicensed personnel (ULP-E, ULP-F) were trained by the registered nurse (RN) and demonstrated competency for administering medications. 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 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). This resulted in an immediate order on December 13, 2022. The findings include: ULP-E ULP-E was hired on October 4, 2022, to provide	01750		

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01750	Continued From page 50 direct care services under the licensee's assisted living with dementia care license. ULP-E's training record indicated licensed practical nurse (LPN)-B trained ULP-E in medication administration. ULP- E's training record lacked evidence ULP-E had been trained by the RN and demonstrated competency in medication administration. R4's medication administration record (MAR) for November 2022, indicated ULP-E administered R4's morning medications on November 5 and 6, 2022. R4's MAR for December 2022, indicated ULP-E administered R4's evening medications on December 5, 2022. ULP-F ULP-F was hired on November 25, 2022, to provide direct care services under the licensee's assisted living with dementia care license. ULP-F's training record indicated LPN-B trained ULP-E in medication administration. ULP- F's training record lacked evidence ULP-F had been trained by the RN and demonstrated competency in medication administration. R1's MAR for December 2022, indicated ULP-F administered R1's evening medication on December 5, 2022. On December 13, 2022, at 3:01 p.m., RN-A confirmed LPN-B had trained ULP-E and ULP-F in medications administration and ULP-E and ULP-F had demonstrated competency in	01750		

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01750	Continued From page 51 medication administration to LPN-B. RN-A stated LPN-B had received "Train the Trainer" training and then RN-A delegated medication administration training to LPN-B. RN-A stated I "comp" her off on the Assisted Living Overview, PCA (personnel care attendant) training document as you have seen per what our staff have and then all medication administration specific competencies. We go through return demo's, just as we do for staff. The licensee's Medication Administration by Unlicensed Personnel policy revised August 21, 2021, indicated no unlicensed personnel may administer medications or assist with self-administration of medications for assisted living residents until they have taken and have successfully passed competency testing under the direction of the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 52 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medication was administered as prescribed and per manufacturer's instructions for one of one resident (R1) who received topical medication. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The finding include: R1's diagnoses included Alzheimer's disease, Parkinson's disease (a progressive disorder that affects the nervous system), hearing loss, and type two diabetes. R1's service plan dated March 9, 2022, indicated R1 received medication management services. R1's prescriber orders dated March 8, 2022, included an order for Voltaren 1% gel to apply one gram of cream topically to right knee twice a day for pain. R1's Medication Administration Record (MAR) date December 1, 2022, through December 12, 2022, indicated R1 was to receive Voltaren 1% gel one gram of cream topically to right knee	01760		

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01760	Continued From page 53 twice a day. On December 13, 2022, at 7:28 a.m., the surveyor observed unlicensed personnel (ULP)-G put on a pair of disposable gloves, removed the Voltaren gel from the packaging which was stored in the medication cart, opened the tube and dispensed an unmeasured amount of Voltaren gel into her gloved hand and applied the Voltaren gel to R1's right knee. On December 13, 2022, at 7:35 a.m., immediately following the above observation, ULP-G confirmed she had not measured the Voltaren gel with the provided dosing card to ensure the correct dose was administered and stated, "I just eyeball it." On December 14, 2022, at 12:13 p.m., registered nurse (RN)-A stated staff should be using the dosage card provided with the Voltaren cream to measure for accurate dosage. The licensee's Storage of Medications policy dated December 2019, indicated medications shall be stored consistent with manufacturer's recommendations. The manufacturer instructions for the use of Voltaren's dated February 2018, indicated Voltaren gel should be measured onto the enclosed dosing card. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01790	Continued From page 54	01790		
01790 SS=E	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in	01790		

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01790	Continued From page 55 the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of four employees (unlicensed personnel (ULP)-E, ULP-F) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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	01790		

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01790	Continued From page 56 found to be pervasive). The findings include: During the entrance conference on December 12, 2022, at 11:00 a.m., registered nurse (RN)-A stated the licensee provided medication management services to 49 residents and the ULP would prepare and send medications with the residents for unplanned times away. ULP-E ULP-E was hired on October 4, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R4's December 2022, medication administration record (MAR) indicated ULP-E administered R4's scheduled evening medications on December 5, 2022, and R4's scheduled morning medications December 10 and 11, 2022. ULP-E's employee record indicated licensed practical nurse (LPN)-B trained ULP-E on sending medication when a resident goes on LOA (leave of absence). ULP-E's employee record lacked evidence the RN has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents for unplanned time away from home. ULP-F ULP-F was hired on November 25, 2022, to provide direct care services under the licensee's assisted living with dementia care license. ULP-F's employee record indicated licensed practical nurse LPN-B trained ULP-F on sending	01790		

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01790	Continued From page 57 medication when a resident goes on LOA. ULP-F's employee record lacked evidence the RN has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents for unplanned time away from home. On December 13, 2022, at 3:01 p.m., RN-A confirmed LPN-B had trained ULP-E and ULP-F in sending medications when a resident goes on LOA and ULP-E and ULP-F had demonstrated competency in sending medications when a resident goes on LOA to LPN-B. RN-A stated LPN-B had received "Train the Trainer" training and then RN-A delegated medication administration training to LPN-B. RN-A stated I "comp" her off on the Assisted Living Overview, PCA (personnel care attendant) training document as you have seen per what our staff have and then all medication administration specific competencies. We go through return demo's [demonstrations], just as we do for staff. The licensee's Medication Administration-Planned and Unplanned Time Away policy dated November 2019, indicated for unplanned client time away when a pharmacist or licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: - The registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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01880	Continued From page 58	01880		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 12, 2022, at 11:20 a.m., during entrance conference, registered nurse (RN)-A and licensed practical nurse (LPN)-B indicated the licensee provided medication management services to the licensee's residents, including storage of medication. RN-A stated residents on Vindauga View had refrigerators in their rooms and if any of those residents had medications that required refrigeration, the medications would be stored in a locked box in the resident's refrigerator. RN-A stated residents' refrigerator temperatures were not being monitored. RN-A	01880		

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01880	Continued From page 59 stated the medication refrigerator temperatures were being monitored on Margaret House. The surveyor requested three months of temperature logs to review. On December 12, 2022, at 2:57 p.m., during the tour on Margaret House, LPN-B confirmed temperatures were not being monitored for the medication refrigerator located in the caregiver's office. On December 13, 2022, at 10:23 a.m., unlicensed personnel (ULP)-I confirmed temperatures were not being recorded daily for the medication refrigerator and the refrigerator did not have a thermometor. ULP-I confirmed the medication refrigerator on Margaret House contained the following: -one unopened bottle of latanoprost 0.005% eye drop (used to high pressure inside the eye). The manufacturer's instructions for latanoprost eye drops are to store unopened bottles under refrigeration at 36 degrees Fahrenheit (F) to 46 degrees F. The licensee's Storage of Medication policy dated December 2019, indicated medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 60 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expiration dates for R6 and R7. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 December 12, 2022, at 2:53 p.m., the surveyor observed the medication cart stationed in the assisted living office with licensed practical nurse (LPN)-B confirming the following: -R6's opened bottle of Dorzolamide/Timolol (medication to treat glaucoma) lacked the date the eye drop had been opened and when the eye drop would expire. -R7's opened bottle of Timolol (medication to treat glaucoma) lacked the date the eye drop had been opened and when the eye drop would expire.	01890		

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01890	Continued From page 61 On October 17, 2022, at 11:27 a.m., LPN-B confirmed time-sensitive medication such as eye drops should be dated after opening to include the date the medications would expire. The manufacturer's instructions for Dorzolamide eye drop dated January 2020, indicated to use within 28 days after opening, then discard bottle. The manufacturer's instructions for Timolol eye drop dated January 2020, indicated to use within 28 days after opening, then discard bottle. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=G	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	01950		

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01950	Continued From page 62 in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prior to delegating treatments and therapies, the unlicensed personnel (ULP) were trained by the registered nurse (RN) in the proper methods to perform the treatment or therapy for each resident and were able to demonstrate the ability to competently follow the procedure to perform the treatment or therapy for one of one employee (ULP-F). 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 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). This resulted in an immediate order on December 13, 2022. The findings include: ULP-F was hired on November 25, 2022, to provide direct care services under the licensee's assisted living with dementia care license. R2's diagnoses included diabetes type 2, heart failure, shortness of breath, atrial fibrillation (irregular heartbeat), and hypothyroidism (low thyroid levels).	01950		

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01950	Continued From page 63 R2's December 2022, MAR indicated ULP-F obtained R2's blood oxygen saturation level and R2's blood glucose monitoring on December 11, 2022, at approximately 8:00 p.m. ULP- F's training record lacked evidence ULP-F had been trained by the RN and demonstrated competency in blood glucose monitoring and monitoring blood oxygen saturation levels. On December 13, 2022, at 3:01 p.m., RN-A confirmed licensed practical nurse (LPN)-B had trained ULP-F in blood glucose monitoring and oxygen saturation levels and confirmed ULP-F had demonstrated competencies to LPN-B. RN-A stated LPN-B had received "Train the Trainer" training and then RN-A delegated medication administration training to LPN-B. RN-A stated I "comp" her off on the Assisted Living Overview, PCA (personnel care attendant) training document as you have seen per what our staff have and then all medication administration specific competencies. We go through return demo's, just as we do for staff. The licensee's Training and Competency Evaluation for Unlicensed Personnel policy dated November 2019, indicated when a registered nurse or licensed health professional delegates tasks, they must make certain that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01950		

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01950	Continued From page 64 On December 14, 2022, immediacy was removed, however, non-compliance remains at an isolated scope, level three (G). TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. Mitigation of property hazards to protect residents from harm was not included. 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	02040		

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02040	Continued From page 65 or has the potential to affect a large portion or all of the residents). The findings include: On December 12, 2022, at approximately 2:15 p.m., the licensed assisted living director (LALD)-C provided a hazard vulnerability assessment dated 12.10.2019. The hazard vulnerability assessment did not include hazards or safety risks identified on and around the property. Mitigation of property hazards to protect residents from harm was not included. On December 12, 2022, at approximately 2:50 p.m., the LALD-C confirmed the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in	02410		

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02410	Continued From page 66 the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy was maintained during medication administration 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, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included Alzheimer's disease, Parkinson's disease (a progressive disorder that affects the nervous system), hearing loss, and type two diabetes. R1's service plan dated March 9, 2022, indicated R1 received the following services: medication management, dressing, grooming, transferring, toileting, and housekeeping. On December 13, 2022, at 7:28 a.m., unlicensed	02410		

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02410	Continued From page 67 personnel (ULP)-G was observed lifting the back of R1's shirt and applied a Lidocaine patch (pain reliever) to R1's right lower back and then applied Voltaren gel (pain reliever) to R1's right knee while R1 was sitting at the dining table during breakfast with other residents present. On December 14, 2022, at 12:13 p.m., registered nurse (RN)-A stated creams and lidocaine patches should be applied in a private setting due to exposing of the resident's skin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		
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 signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20872	A. BUILDING: _____ B. WING _____	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARMLY ON THE LAKE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(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
03090	Continued From page 68 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 the potential to affect a large portion or all the residents). The findings include: During the initial facility tour on December 12, 2022, at 2:53 p.m., with licensed practical nurse (LPN)-B, the surveyor noticed a sign pertaining to the residents having electronic monitoring in their apartments. The sign posted at the main entrances lacked the required statutory language for the notice of electronic monitoring. On December 14, 2022, at 10:30 a.m., licensed assisted living director (LALD)-C confirmed the sign posted at the main entrances lacked the required statutory language for the notice of electronic monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/12/22*
Time: 12:00:00
Report: 1025221268

Food and Beverage Establishment Inspection Report

Location:
Parmly On The Lake
28210 Old Towne Road
Chisago City, MN55013
Chisago County, 13

Establishment Info:
ID #: 0038378
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512577334
ID #:

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

The following orders were issued during this inspection.

3-500B 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.

Cold TCS foods in Margaret, Izzy coolers above 41 deg F; maintain cold TCS foods at or below 41 deg F.

Comply By: 12/12/22

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

Hardboiled eggs in container in Margaret cooler labeled for use thru 12-20 on 12/12; use or discard TCS foods prepared or opened from a prepared package within 7 days. Eggs were discarded.

Corrected on Site

3-700 Contaminated Food: discarded

3-701.11A ** Priority 1 **

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

Discard TCS items from Margaret cooler, Izzy cooler, and any coolers in the facility where TCS food is not held at or below 41 deg F.

Comply By: 12/12/22

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

Dish machine in Main Kitchen, Izzy, failed to reach internal contact temperature of 160 deg F. Discontinue use for sanitizing; service units and verify before use for sanitizing.

Comply By: 12/12/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Provide coolers in Izzy kitchen that meets the above standards for storing TCS foods (facility prepares foods for multi-day service). See additional comments.

Comply By: 12/12/22

6-300 Physical Facility Numbers and Capacities

6-304.11A

MN Rule 4626.1475A Provide sufficient mechanical tempered make-up air and exhaust ventilation to keep rooms free of grease, excessive heat, steam condensation, vapors, obnoxious or disagreeable odors, smoke, and fumes according to State Building and Mechanical codes.

Ambient air temperature in Vind[aga?]/serving kitchen at 85 deg F. Coolers often are spec'd to operate at a maximum air temperature of 76 deg F; ensure sufficient make-up air is available in the serving kitchen (and when appliances are running).

Comply By: 12/16/22

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: Kitchen dish machine < 160
Violation Issued: Yes

Hot Water: = at 160 Degrees Fahrenheit
Location: Serving kitchen dish machine
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Margaret dish machine
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location: Izzy dish machine < 160
Violation Issued: Yes

"Sink & Surface" DDBSA: = OK at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Vegetable dish
Temperature: 160 Degrees Fahrenheit - Location: Hot holding, leftover, main kitchen serving line
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: 2 door serving cooler, main kitchen
Violation Issued: No

Process/Item: Cheese, pkg
Temperature: 41 Degrees Fahrenheit - Location: Back prep cooler, 2 door
Violation Issued: No

Process/Item: Lettuce, shredded, pkg
Temperature: 40 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Eggs, HB
Temperature: 47 Degrees Fahrenheit - Location: Cooler, Izzy
Violation Issued: Yes

Process/Item: H&H, pkg
Temperature: 45 Degrees Fahrenheit - Location: Cooler, Margaret
Violation Issued: Yes

Process/Item: Milk
Temperature: 38 Degrees Fahrenheit - Location: Upright cooler, serving kitchen (V)
Violation Issued: No

Process/Item: Soup, bagged
Temperature: 38 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Meat patty, pkg
Temperature: 36 Degrees Fahrenheit - Location: Frozen, receiving
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	4	0	2

Discussed employee health and hygiene, illness reporting and exclusion, cooling (cool before bagged/storage), food source, returnables to quarantine rooms (reported disposables used), sanitizing, chemical use (Sink and Surface used, test kit available); high temperature dish machine irreversible stickers available; TMD available.

Appropriate sanitizer in-use (Sink and Surface); direct staff to fill sanitary buckets from the 3 compartment sink dispenser, as this dispenser tested correctly on a small volume of solution; mop sink dispenser may not dispense correctly for small volumes.

4626.0506 Equipment
For coolers in Assisted Living locations (and for other licenses/licensed areas with food preparation or storage in coolers/refrigerators), equipment standards are contained in 4626.0506. Search "MDH Equipment Standards" for more information. Foods are prepared for multi-day service ([G] applies to same-day service).

Segregate and store medication away from food.
4626.1665 REFRIGERATED MEDICINES; STORAGE.
Medicines belonging to employees or children in a day care center that require refrigeration and are stored in a food refrigerator [_] must be stored in a package or container and kept inside a covered, leakproof container that is identified as a container for the storage of medicines [_]

Language specifies children in care settings, so additional care should be taken for storage in care areas in the facility. Technically, medications should be stored per any applicable requirements outside of MN Food Code, and TCS foods need to be stored in a cooler meeting the requirements above, and segregated from non-food items (chemicals, medications, etc). It may be most practical and compliant to store medications in existing coolers not meeting the requirements of 4626.0506, and store food in separate coolers which meet the requirements of 4626.0506.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

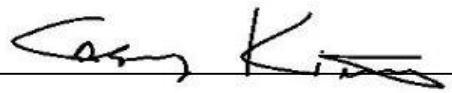
I acknowledge receipt of the Minnesota Department of Health inspection report number 1025221268 of 12/12/22.

Certified Food Protection Manager: Karen Immel

Certification Number: FM333 Expires: 12/18/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Karen

Signed: 

Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025221268

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	4	Date	12/12/22
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

Parmly On The Lake	Address: 28210 Old Towne Road	City/State: Chisago City, MN	Zip Code: 55013	Telephone: 6512577334

License/Permit #: 0038378	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Food Recalls:

Person in Charge (Signature) **Date:** 12/13/22

Inspector (Signature) Cory Kline