Electronically Delivered

July 13, 2023

Licensee
Fairway Pines Senior Living
606 Main Street North
Sauk Centre, MN 56378

RE: Project Number(s) SL29188015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 28, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29188	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY PINES SENIOR LIVING	606 MAIN STREET NORTH SAUK CENTRE, MN 56378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL29188015-0 On June 26, 2023, through June 28, 2023, 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 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (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 June 26, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in	0 485		

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0 485	Continued From page 2 advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post a menu a week in advance that was made available to all residents on the secured unit. This had the potential to affect all 8 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 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: On June 26, 2023, at approximately 11:15 a.m., during a tour of the facility with licensed assisted living director (LALD)-A the surveyor did not observe a menu for the day or for the week posted in the secured unit. On June 26, 2023, at 11:31 a.m., LALD-A said the menu was "normally on the refrigerator." LALD-A stated the menu was not posted in the secure unit as required.	0 485		

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0 485	Continued From page 3 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two licensed practical nurses (LPN)-E, during wound care. In addition, the licensee failed to ensure infection control standard was followed for one of three unlicensed personnel (ULP)-G, during medication administration. 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	0 510		

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0 510	Continued From page 4 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: WOUND CARE LPN-E On June 26, 2023, at 1:45 p.m., the surveyor observed LPN-E ask R5 to go to his room to perform wound care. The surveyor observed LPN-E with gloved hands. LPN-E attempted to remove a band aide dated June 23, 2023, from the top of R5's left hand. R5 suggested to LPN-E to use an alcohol pad to aid in the band aide's removal. LPN-E removed her right glove and walked to a dresser positioned near the bathroom door in R5's room and pick up an alcohol prep pad from a box sitting on top of the dresser. LPN-E opened the packaging and used the alcohol pad to assist in removing the band aide. Once the band aide had been removed LPN-E donned her right hand with a new glove. LPN got a washcloth, took it to the sink and ran water on it and wrung it out. LPN-E took the washcloth to R5 and cleansed the top of his left hand, commenting she was "trying to get dried blood off." LPN-E then dabbed the top of R's hand with paper towel and removed the gloves she had been wearing. LPN removed a band aide from her pocket and dated the band aide and applied it to the top of R5's left hand. LPN-E went to the sink and rinsed out the washcloth with water and wrung it out. The surveyor did not observe LPN-E perform hand hygiene after removing glove or reapplying gloves. The surveyor did not observe LPN-E wear gloves when rinsing out the washcloth used to remove body fluids.	0 510		

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0 510	Continued From page 5 On June 26, 2023, at 2:09 p.m., LPN stated she had not washed her hands in between glove changes, and she did not wear gloves when rinsing out the washcloth that had been used to removed "dried blood." LPN-E added she did not "perform" well under pressure. She then showed the surveyor a container of hand sanitizer she had in her pocket. On June 26, 2023, at 2:23 p.m., clinical nurse supervisor (CNS)-C stated hand hygiene should be done when going from dirty to clean and between glove changes or to use sanitizer. In addition, CNS-C stated gloves should be worn when rinsing out wash cloth when body fluids had been involved. MEDICATION ADMINISTRATION ULP-G On June 27, 2023, at 6:37 a.m., the surveyor observed ULP-G in R8's room wearing gloves. ULP-G was in the process of medication administration. ULP- G gave R8 his medication via a spoon and with water. ULP-G removed the gloves and went to find the "tablet" to document medication administration. On June 27, 2023, at 6:43 a.m., ULP-G stated she forgot to wash her hands after removing gloves. On June 27, 2023, at approximately 11:45 a.m., CNS-C stated hand hygiene should be performed after removing gloves. The licensee's Hand Hygiene policy (Based upon the CDC (Center for Disease Control) Guideline Hand Hygiene in Healthcare Settings) reviewed July 2021, noted: -hand washing would be performed by all	0 510		

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0 510	Continued From page 6 employees, as necessary, between tasks and procedures, and after bathroom use to prevent cross-contamination Alcohol Based Hand Sanitizer: -before moving from a soiled body site to a clean body site on same resident -after touching a resident or the resident's immediate environment -after contact with blood, body fluids or contaminated surfaces - immediately before putting on gloves and after glove removal No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=D	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common	0 640		

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0 640	Continued From page 7 areas in the secured unit to include posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect 8 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: During a facility tour of the secured unit on June 26, 2023, at approximately 11:15 a.m., with licensed assisted living director (LALD)-A, the surveyor observed a cordless phone in a base in the open kitchen/commons area. The surveyor did not observe the emergency number, 911, posted near telephone or in commons area. On June 26, 2023, at 11:30 a.m., LALD-A confirmed the secured unit did not have 911 posted in common area and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 8 (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 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 review, the licensee failed have a written emergency preparedness plan (EPP) posted in a prominent area and developed with all the required content. 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	0 680		

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0 680	Continued From page 9 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 26, 2023, at approximately 11:30 a.m., during a tour of the facility with licensed assisted living director (LALD)-A, the surveyor did not observe the facility's EPP in a prominent area. On June 26, 2023, at 11:36 a.m., LALD-A stated the Emergency Preparedness Operations plan was kept in the nurse's station and not in a prominent area. The licensee's EPP last reviewed September 29, 2022, failed to include the following: -process for emergency preparedness (EP) cooperation with local, tribal, regional, state, and local EP officials/organizations -identification of which staff would assume specific roles in another's absence through succession planning and delegation of authority -procedures for tracking of staff and patients -communication plan to include contact information for office of ombudsman for LTC (long term care) -missing person policy reviewed quarterly. On June 28, 2023, at 9:00 a.m., the facility's EPP was reviewed with LALD-A. LALD-A stated the facility's EPP did not contain all the required information. LALD-A added some of the information was in the survey binder or posted in the facility. LALD-A added she was not aware the missing person policy was to be reviewed quarterly.	0 680		

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0 680	Continued From page 10 The licensee's Assisted Living Disaster and Emergency Plan guidelines dated September 23, 2022, noted the most recent version of [licensee's] Emergency Disaster plan was posted for easy access by residents, staff, visitors and vendors at front desk. In addition, corrections and updated information would be incorporated into the plan and staff should be in-serviced accordingly. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 11 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on June 27, 2023, at approximately 1:00 p.m. with the licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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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
0 810	Continued From page 12 Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. The policy stated that staff are to be trained upon hire and then once per year thereafter. During interview, LALD-A verified the licensee followed their written policy and trained staff upon hire and then once annually using their community fire plan. LALD-A stated that staff also received "fire safety basics" training online twice a year, but the content is not specific to the facility. LALD-A verified these deficient findings at the time of the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident agreement arbitration requirement did not include a choice of venue provision. This practice resulted in a level one violation, and	0 980		

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	29188	A. BUILDING: _____ B. WING _____	06/28/2023

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0 980	Continued From page 13 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: During the entrance conference on June 26, 2023, at 11:19 a.m., the surveyor requested a copy of the licensee's assisted living contract. The assisted living contract, Arbitration Agreement and Resident Handbook (considered part of the assisted living contract) were provided and later reviewed by the surveyor. The facility's Assisted Living Contract included an arbitration section. On page 13 through 14, number two- Termination by Provider, section D - Resident's Default of the assisted living contract indicated any arbitration conducted pursuant to this Resolution of Legal Disputes shall be conducted within the county wherein this community [assisted living] is located. The Arbitration Agreement included on page two- section Location of Arbitration indicated arbitration will be conducted at a site selected by the facility which shall be either at the facility or somewhere within a reasonable distance of the facility. On June 26, 2023, at 3:25 p.m., licensed assisted living director (LALD)-A stated the assisted living contract and arbitration agreement stated the facility would choose the location of an arbitration and was used for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	0 980		

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0 980	Continued From page 14 (21) days	0 980		
01420 SS=F	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 the 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) provided written instructions in the resident's record for the delegated tasks provided by the unlicensed personnel (ULP) for three of three residents (R6, R8, R5) using Broda Chair (a wheelchair offering tilt-n-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture) motion alarm (special type of sensor that alerts movement) and skin care and catheter care (a tube that is inserted into your bladder, allowing your urine to drain freely.) This practice resulted in a level two violation (a	01420		

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01420	Continued From page 15 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: BRODA CHAIR R6 R6's diagnoses include cognitive decline, unspecified dementia without behavioral disturbance, major depression, and anxiety disorder. R6's service plan dated November 1, 2022, indicated the resident required assistance with transfer assist, toileting, grooming assist, dressing assist, and bathing assist. On June 26, 2023, at 8:37 a.m., the surveyor observed ULP-D and an unidentified ULP use a sit to stand lift (mechanical) to transfer R6 from a recliner chair into a Broda chair. Once in the chair ULP-D adjusted the foot pedals on the Broda chair. R6's record lacked evidence of specific written instructions for the ULP to follow regarding the Broda chair. On June 26, 2023, at 2:07 p.m., clinical nurse supervisor (CNS)-C stated they only had one specialized wheelchair," Broda" at this time. CNS-C said there were no instructions in R6's record for the Broda chair, "nothing for staff to follow."	01420		

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01420	Continued From page 16 ALARMS R8 R8's diagnoses include late onset Alzheimer's disease with behavioral disturbance and major depressive disorder. R8's service plan dated June 6, 2023, indicated the resident required assistance with escorts, behavior observation, transfer-cueing/standby assistance and bedtime routine. R8's provider's order dated June 17, 2023, included sensor alarm in bed due to multiple falls from bed. On June 27, 2023, at 6:37 a.m., the surveyor observed ULP-G administer R8's 6:00 a.m. medication. ULP-G left R8's room and a few minutes later ULP-G was alerted that R8's alarm was sounding. ULP-G commented, "he just laid back down. Happens [alarm sounds] when he puts his arms up also." ULP-G added motion alarms were in all the bathrooms and R8 has an alarm on "all the time" when in bed. R8's record lacked evidence of specific written instructions for the ULP to follow regarding use of the motion alarm. On June 28, 2023, at 9:40 a.m., CNS-C stated R8's record did not contain any instructions for staff regarding motion alarm use when in bed. CNS-C said all the bathrooms in the secured unit have motion sensors, adding R8 was a "special case." SKIN CARE/CATHETER CARE R5 R5's diagnoses include cerebral palsy (congenial	01420		

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01420	Continued From page 17 disorder of movement, muscle tone, or posture), mild cognitive impairment, prostate cancer, and heart disease with heart failure. R5's service plan dated January 30, 2023, indicated skin care three (3) times daily, and catheter care three (3) times daily. R5's Service Checkoff List dated June 1, 2023, through June 26, 2023, indicated: -skin care, redness in right armpit. Cleanse with soap and water, pat dry and apply nystatin powder -catheter care, provide catheter care once every shift. Empty and measure urine. Apply Corona cream (skin protectant) to coccyx. Apply gloves, always hold catheter at the insertion site (urinary meatus) with one hand to prevent tension/ pulling and potentially dislodging the catheter with the other hand, wipe the catheter downwards using disposable wipes or a clean cloth and soap and water. Wipe the tubing away from the meatus for approximately "4aC" (sic) of catheter tubing. Use a new wipe or side of cloth for each swipe down the catheter tubing 2-4 times. Using a clean wipe or cloth, complete peri care by cleaning the meatus gently (vigorous rubbing can lead to irritation and potential infection). Finish peri care by further cleaning around the peri area. On June 26, 2023, at 1:55 p.m., the surveyor observed two (2) unidentified ULPs assist R5 into bed using a mechanical lift. Once in bed a ULP positioned R5's catheter bag on R5's bed frame. On June 27, 2023, at 7:23 a.m., the surveyor observed ULP-D wash R5's right arm pit with soap and water and pat the area dry and apply nystatin powder (yeast).	01420		

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01420	Continued From page 18 R5's record lacked evidence of specific written instructions for the ULP to follow regarding skin care and catheter care. On June 27, 2023, at 2:28 p.m., CNS-C stated R5's record lacked specific instructions for R5's skin care and catheter care, when to report issues/concerns to nursing. The licensee's Nursing Services policy dated March 2021, noted a registered nurse could delegate nursing services to ULP after: -completing a nursing assessment of the cline's functional status and need for nursing services -developing a service plan for providing the services according to the client's needs and preferences -determining that the ULP was trained and competent and had been instructed in the proper methods to perform the procedures with respect to the specific client, and -include written instructions for performing the procedure for the client in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

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01620	Continued From page 19 (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 observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted assessments with the uniform assessment tool that included all required content for four of four residents (R2, R3, R4, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R2 R2's diagnoses included hypertension (HTN-high	01620		

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01620	Continued From page 20 blood pressure), shortness of breath and osteoarthritis. R2's 90 Day New Nursing Assessments were completed January 31, 2023, and April 27, 2023, respectively. On June 27, 2023, at 1:56 p.m., the surveyor observed unlicensed personnel (ULP)-I change R2's portable oxygen battery. R3 R3's diagnoses included congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), chronic kidney disease (kidneys are damaged and can't filter blood effectively) and gastroesophageal reflux disease (GERD-chronic disease that occurs when stomach acid or bile flow irritates the lining). R3's 90 Day New Nursing Assessments were completed March 13, 2023, and June 7, 2023, respectively. On June 27, 2023, at 7:19 a.m., the surveyor observed licensed practical nurse (LPN)-F provide scheduled morning medication administration to R3. R4 R4's diagnosis included diabetes, chronic kidney disease and osteoarthritis. R4's 90 Day New Nursing Assessments were completed February 3, 2023, and May 4, 2023, respectively. On June 27, 2023, at 8:34 a.m., the surveyor observed LPN-F complete a blood glucose check	01620		

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01620	Continued From page 21 for R4. R7 R7's diagnoses included HTN, CHF, and chronic obstructive pulmonary disease (COPD- a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation). R7's 90 Day New Nursing Assessment was completed June 14, 2023. On June 27, 2023, at 8:42 a.m., the surveyor observed LPN-F complete the scheduled morning medication administration for R7. R2, R3, R4 and R7's 90 Day New Nursing Assessment forms lacked the resident's personal lifestyle preferences including: spiritual and cultural preferences. On June 27, 2023, at 12:00 p.m., clinical nurse supervisor (CNS)-C stated the 90 day assessment form used for all residents lacked cultural and spiritual preferences of each resident. The licensee's undated Minnesota Clinical Assessment Guide for AL (assisted living) and MC (memory care) noted a nursing assessment would be done at least every 90 days using the level of care tool (uniform assessment tool). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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01640	Continued From page 22	01640		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date 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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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 two of four residents (R4, R6) service plans were revised to include provided services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01640		

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01640	Continued From page 23 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4's diagnosis include diabetes, chronic kidney disease (kidneys are damaged and can't filter blood effectively) and osteoarthritis. R4's service plan dated February 4, 2023, indicated licensed practical nurse (LPN) to complete blood glucose monitoring daily. R4's electronic medication administration record dated June 2023, indicated staff to check R4's blood glucose every day at 8:00 a.m. and 4:00 p.m. On June 27, 2023, at 8:34 a.m., the surveyor observed LPN-F complete a blood glucose check for R4. R4's service plan lacked revision to complete blood glucose monitoring twice per day. On June 26, 2023, at 1:10 p.m., clinical nurse supervisor (CNS)-C stated R4's service plan was not revised to reflect blood glucose monitoring twice per day. R6 R6's diagnoses include cognitive decline, unspecified dementia without behavioral disturbance, major depression, and anxiety disorder. R6's service plan dated November 1, 2022, indicated the resident required assistance with	01640		

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01640	Continued From page 24 transfer assist at 4:30 a.m., toileting/incontinence care 11:00 a.m., 1:00 p.m., 4:45 p.m., 7:00 p.m., 8:45 p.m., 12:00 a.m., 4:30 a.m., grooming assist, dressing assist, and bathing assist. On June 26, 2023, at 2:12 p.m., the surveyor observed an unidentified staff pushing R6's Broda wheelchair (a wheelchair offering tilt-n-space positioning with a seating system which prevents skin breakdown through reducing heat and moisture) into the secure unit. On June 27, 2023, at 8:37 a.m., the surveyor observed unlicensed personnel (ULP)-D and an unidentified ULP use a sit to stand lift (mechanical) to transfer R6 from a recliner chair into a Broda chair. On June 27, 2023, at 11:23 a.m., regional director of clinical services (RDCS)-J stated toileting "counts" as a transfer. On June 27, 2023, at 12:09 p.m., CNS-C stated R6's service plan was not revised as required to include escorts and transfer assistance during the day and afternoon. The licensee's Service Plan policy dated April 2023, noted the service plan must be revised, if needed, based on the results of required client monitoring and /or reassessments. The service plan and any revised service plans must be entered into the client's record, including notice of a change in a client's fees. The licensee's Nursing Services policy dated March 2021, noted a registered nurse could delegate nursing services to ULP after: -developing a service plan for providing the services according to the client's needs and	01640		

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01640	Continued From page 25 preferences No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of four residents (R8). 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	01750		

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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
01750	Continued From page 26 situation has occurred only occasionally). The findings include: R8's diagnoses include glaucoma (high pressure in eyes), late onset Alzheimer's disease with behavioral disturbance and major depressive disorder. R8's service plan dated June 6, 2023, indicated the resident required assist with medication administration: 6:30 a.m., 8:00 a.m., 2:00 p.m., 7:00 p.m. R8's prescriber's order dated June 17, 2023, included: -dry eye relief drops 0.2-0-2-3% solution twice a day, one (1) drop to both eyes -dorzolamide HCL (glaucoma/high eye pressure) 2 % solution one drop into both eyes three times daily -latanoprost 0.005% (glaucoma) solution one (1) drop both eyes daily at bedtime R8's medication administration record (MAR) dated June 1, 2023, through June 27, 2023, included: -dry eye relief drops 0.2-0.201 % solution/ Artificial Tears, one (1) drop to both eyes twice a day: 7:00 a.m., 1:00 p.m. -dorzolamide HCI solution, one (1) drop into both eyes three (3) times daily: 8:00 a.m., 2:00 p.m., 7:30 p.m. -latanoprost 0.005% solution one (1) drop both eyes daily at bedtime: 7:30 p.m.***must be refrigerated until opened. Good for 42 days once opened or expiration date on bottle; whatever one is first*** On June 27, 2023, at 7:57 a.m., the surveyor	01750		

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	29188	A. BUILDING: _____ B. WING _____	06/28/2023

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01750	Continued From page 27 observed unlicensed personnel (ULP)-D remove R8's oral medication, dorzolamide and Artificial Tears bottles, Lidocaine 4% patch (pain) and Voltaren gel (topical pain treatment) from a locked medication cart. ULP-D instilled one (1) drop of Artificial Tears into both eyes, prepared and administered R8's oral medication, applied a pain patch and instilled one (1) drop of dorzolamide into both eyes, and applied Voltaren gel. On June 27, 2023, at 8:07 a.m., ULP-D stated there were no instructions on the MAR regarding R8's eye drops, adding, "I know you are supposed to wait five minutes in between eye drops. I am in nursing school." On June 27, 2023, at 10:20 a.m., clinical nurse supervisor (CNS)-C said R8's eye drops could be given during the same medication pass, adding they [ULPs] have a one-hour window to give medications. CNS-C stated R8's MAR did not have specific instructions for ULPs to wait five minutes between eye drops. Manufacturer's instructions for dorzolamide dated May 1, 2023, noted if your doctor ordered two different eye drops to be used together, wait at least five (5) minutes between the times you apply the medications. This will help to keep the second medication from "washing out" the first one. Manufacturer's instructions for latanoprost dated February 1, 2023, noted if you will be using latanoprost with other eye medication, use them at least five (5) minutes apart from each other. The licensee's Medications and Treatments policy dated March 2021, noted a registered nurse	01750		

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01750	Continued From page 28 must, specify, in writing, specific instructions for each tenant and document those instructions in the tenants' record No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered per manufacturer's instructions and the licensee's policy for two of four residents (R7, R5) observed during medication administration. In addition, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel/ULP-D) observed administering	01760		

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01760	Continued From page 29 medications for one of five residents (R5). 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: During the entrance conference on June 26, 2023, at 10:48 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. MANUFACTURER'S INSTRUCTIONS R7 R7's diagnoses include unspecified hypertension (high blood pressure), congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs) and chronic obstructive pulmonary disease (COPD-a progressive lung disease characterized by long-term respiratory symptoms and airflow limitation). R7's service plan dated June 14, 2023, indicated R7 received medication administration three (3) times daily. R7's prescriber orders dated November 7, 2022, included an order for Advair 115-21 micrograms (mcg) inhaler- inhale two (2) puffs twice daily and rinse mouth after.	01760		

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01760	Continued From page 30 R7's June 2023 electronic medication administration record (EMAR) indicated Advair HFA 115-21 mcg administer inhaler two (2) puffs twice per day, rinse mouth after and spit. On June 27, 2023, at 8:42 a.m., the surveyor observed licensed practical nurse (LPN)-F conduct a medication pass for R7, which included administration of the Advair 115-21 mcg inhaler. LPN-F shook the Advair inhaler for (5) seconds, handed the Advair inhaler to R7 for self-administration and R7 returned the Advair inhaler back to LPN-F. LPN-F then asked R7 to take a drink of water and swallowed the water. On June 27, 2023, at 8:52 a.m., LPN-F stated R7 took a drink of water after the inhaler administration and then swallowed the water. LPN-F reviewed R7's electronic medication administration record and stated the instructions indicated to rinse mouth with water and spit. On June 27, 2023, at 9:22 a.m., clinical nurse supervisor (CNS)-C stated residents should rinse mouth with water and spit the water out after an inhaler administration. The manufacturer's instructions for use of Advair inhaler dated August 2020, indicated to rinse mouth with water after use and spit out the water, do not swallow the water. DIRECTIONS ON EMAR R5 R5's diagnoses include cerebral palsy (congenial disorder of movement, muscle tone, or posture), mild cognitive impairment, prostate cancer, and heart disease with heart failure.	01760		

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01760	Continued From page 31 R5's service plan dated January 30, 2023, indicated R5 received medication administration three (3) times daily. R5's providers orders dated June 6, 2023, included bicalutamide (prostate cancer) 50 milligrams (mg) tabs, daily, by mouth one (1) time a day: **Wear gloves when dispensing** **No pregnant/nursing staff to dispense** R5's EMAR dated June 1, 2023, through June 26, 2023, included bicalutamide 50 mg one (1) time a day, 8:00 a.m.: **Wear gloves when dispensing** **No pregnant/nursing staff to dispense** On June 27, 2023, at 7:12 a.m., the surveyor observed ULP-D use hand sanitizer and remove R5's 8:00 a.m. medications to include bicalutamide 50 mg and administer them to R5. The surveyor did not observe ULP-D apply gloves at any time during the medication administration process. On June 27, 2023, at 7:21 a.m., ULP-D stated, "if I saw that, [to wear gloves when dispensing], I would have worn gloves." On June 27, 2023, at 9:44 a.m., CNS-C stated ULPs should wear gloves as written on the MAR when administering medications, adding "we went over that in training." Manufacturer's instructions dated May 2022, for bicalutamide noted caretakers should not handle medicine with bare hands and should wear latex gloves. The licensee's Medications and Treatments policy	01760		

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01760	Continued From page 32	01760		

dated March 2021, noted to compare the information on the medication administration record with the label on the medication container and follow any special instructions listed.

MEDICATION ADMINISTRATION PROCESS R5
On June 27, 2023, at 7:23 a.m., the surveyor observed ULP-D wash R5's right arm pit with soap and water and pat the area dry and apply nystatin powder (yeast). The surveyor did not observe ULP-D document the application of nystatin powder to R5's right arm pit.

R5's Service Checkoff List dated June 1, 2023, through June 26, 2023, indicated:
-skin care, redness in right armpit. Cleanse with soap and water, pat dry and apply nystatin powder.

R5's providers orders dated June 6, 2023, included nystatin powder to moist areas in groin or skin folds, as needed (PRN) for yeast.

On June 27, 2023, at 7:29 a.m., ULP-D stated she documented the application of R5's nystatin powder when she documented medication administration, but she forgot to apply nystatin powder. ULP-D applied R5's nystatin powder after she had documented the powder as administered.

On June 27, 2023, at 9:44 a.m., CNS-C stated documentation was not to be completed before administration of medications/treatments. CNS-C said documentation should be completed after administration.

The licensee's Medications and Treatments policy dated March 2021, noted a registered nurse must

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01760	Continued From page 33 instruct the ULP on the following medication administration tasks before delegating the task to them: -the complete procedure of checking a tenant's medication administration record -the administration of the medication to the tenant -the reminder to self-administer medications -the documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs 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 ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of one resident (R7).	01890		

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01890	Continued From page 34 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on June 26, 2023, at 10:48 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. On June 27, 2023, at 8:42 a.m., the surveyor observed licensed practical nurse (LPN)-F conduct a medication pass for R7, which included administration of the Advair 115-21 micrograms (mcg) inhaler. The Advair inhaler was labeled with an open date of June 23, 2023, however, did not include the date the Advair inhaler would expire. On June 27, 2023, at 8:52 a.m., LPN-F stated the Advair inhaler did not have a label of when it would expire and would have to check with the clinical nurse supervisor (CNS)-C regarding the expiration date of the inhaler. On June 27, 2023, at 9:19 a.m., CNS-C stated time sensitive medications should be labeled with the open date and the expiration date of the medication. The manufacturer's instructions for use of Advair inhaler dated August 2020, noted to throw away the inhaler after 120 inhalations even if the inhaler	01890		

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01890	Continued From page 35 is not empty. The licensee's Medications and Treatments policy dated March 2021, noted Advair inhalers would expire 30 days after opening. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=F	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 in the resident's record; and 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) specified, in writing,	01950		

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01950	Continued From page 36 specific instructions for two of four residents (R2, R3) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 26, 2023, at 11:00 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided treatment services to residents. R2 R2's diagnoses include hypertension (HTN-high blood pressure), shortness of breath and osteoarthritis. R2's service plan dated June 1, 2023, indicated oxygen management to provide support and assistance with R2's management of oxygen use 12 times per day and staff assistance to apply compression stockings (TEDS) daily. On June 27, 2023, at 1:56 p.m., the surveyor observed unlicensed personnel (ULP)-I change R2's portable oxygen battery. R2 was observed to be wearing oxygen via nasal cannula (a thin flexible tube which on one (1) end splits into two (2) prongs that are placed in the nostrils and from which a mixture of air and oxygen flow) at four (4) liters. ULP-I stated staff complete oxygen saturation checks every two (2) hours for R2.	01950		

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01950	Continued From page 37 R2's record lacked specific instructions for ULPs of when to notify the RN regarding oxygen management and TEDS when a problem arises. On June 27, 2023, at 9:09 a.m., CNS-C stated R2's record did not contain specific instructions for ULPs to follow for oxygen management and TEDS. R3 R3's diagnoses include congestive heart failure (CHF), chronic kidney disease (kidneys are damaged and can't filter blood effectively) and gastroesophageal reflux disease (GERD-where stomach content persistently and regularly flows up into the esophagus). R3's service plan dated June 7, 2023, indicated staff assistance to apply TEDS daily. R3's Service Checkoff List dated June 1, 2023, through June 26, 2023, indicated staff to apply TEDS every morning and remove every evening. R3's record lacked specific instructions for ULPs to notify the RN regarding TEDS when a problem arises. On June 27, 2023, at 9:10 a.m., CNS-C stated R3's record lacked specific instructions for TEDS and any resident that wore TEDS would lack specific instructions as the documentation was automated in the electronic resident record. The licensee's Medications and Treatments policy dated March 2021, noted the treatment management plan would identify the procedure for notifying the RN or other licensed staff when a problem arises.	01950		

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01950	Continued From page 38 No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Surveyor: Umlauf, Sara J. Based on observation, interview and record review, the licensee failed to ensure treatment or therapy services were documented for one of one resident (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, 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).	01960		

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01960	Continued From page 39 The findings include: During the entrance conference on June 26, 2023, at 11:00 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided treatment services to residents. R2's diagnoses included hypertension (HTN-high blood pressure), shortness of breath and osteoarthritis. R2's service plan dated June 1, 2023, indicated oxygen management to provide support and assistance with R2's management of oxygen use 12 times per day. R2's prescriber orders dated June 26, 2023, included an order for oxygen therapy two (2) to five (5) liters (L) via nasal cannula (a thin flexible tube which on one (1) end splits into two (2) prongs that are placed in the nostrils and from which a mixture of air and oxygen flow) at rest and exertion. On June 27, 2023, at 1:56 p.m., the surveyor observed unlicensed personnel (ULP)-I change R2's portable oxygen battery. R2 was observed to be wearing oxygen via nasal cannula at four (4) L. ULP-I stated staff complete oxygen saturation checks every two (2) hours for R2. R2's Service Checkoff List dated June 2023, directed staff to assist resident with switching from apartment oxygen concentrator to portable oxygen machine, assist with oxygen, check oxygen rate, and assist to place oxygen cannula on for 11 different times throughout the day. R2's record lacked documentation oxygen therapy had been administered at two (2) - five	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29188	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY PINES SENIOR LIVING	606 MAIN STREET NORTH SAUK CENTRE, MN 56378

(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
01960	Continued From page 40 (5) L as prescribed. In addition, R2's record lacked documentation that oxygen saturation levels were completed every two (2) hours to determine the rate of oxygen flow. On June 28, 2023, at 9:09 a.m., CNS-C stated R2's record lacked documentation oxygen therapy was being administered two (2) - five (5) L via nasal cannula as prescribed and oxygen saturation levels were not documented. The licensee's Medications and Treatments policy dated March 2021, noted all treatment/therapy to be administered as prescribed and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=E	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for two of four residents (R3, R4) who received treatments managed by the provider.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29188	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY PINES SENIOR LIVING	606 MAIN STREET NORTH SAUK CENTRE, MN 56378

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01970	Continued From page 41 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 26, 2023, at 11:00 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided treatment services to residents. R3 R3's diagnoses included congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), chronic kidney disease (kidneys are damaged and can't filter blood effectively) and gastroesophageal reflux disease (GERD-chronic disease that occurs when stomach acid or bile flow irrigates the lining). R3's service plan dated June 7, 2023, indicated staff assistance to apply compression stockings (TEDS) daily. R3's Service Checkoff List dated June 2023, indicated staff to apply TEDS every morning and remove every evening. On June 27, 2023, at 7:19 a.m., the surveyor observed licensed practical nurse (LPN)-F provide scheduled morning medication administration for R3.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29188	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY PINES SENIOR LIVING	606 MAIN STREET NORTH SAUK CENTRE, MN 56378

(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
01970	Continued From page 42 R3's prescriber orders dated February 16, 2022, included an order to apply TEDS on or off as needed per nursing discretion. R3's record lacked annual updated prescriber order for TEDS. On June 28, 2023, at 9:34 a.m., CNS-C stated R3's record did not have an annual updated order for TEDS. R4 R4's diagnosis included diabetes, chronic kidney disease and osteoarthritis. R4's service plan dated February 4, 2023, indicated LPN to complete blood glucose monitoring daily. R4's electronic medication administration record dated June 2023, indicated staff to check R4's blood glucose every day at 8:00 a.m. and 4:00 p.m. On June 27, 2023, at 8:34 a.m., the surveyor observed LPN-F complete a blood glucose check for R4. R4's prescriber orders dated May 24, 2023, included an order to monitor blood sugar daily at 8:00 a.m. R4's record lacked prescriber orders to complete blood glucose monitoring twice per day. On June 27, 2023, at 1:10 p.m., CNS-C stated R4's record lacked a prescriber order to complete blood glucose monitoring twice per day.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY PINES SENIOR LIVING	606 MAIN STREET NORTH SAUK CENTRE, MN 56378

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01970	Continued From page 43 The licensee's Medications and Treatments policy dated March 2021, noted the registered nurse is responsible for assuring that a current, authorized order for medications or treatments administered by the staff are kept on file in the tenant's (resident) record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as	02170		

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	29188	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWAY PINES SENIOR LIVING	606 MAIN STREET NORTH SAUK CENTRE, MN 56378

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02170	Continued From page 44 entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a written individualized activity evaluation that addressed all six provisions. In addition, the licensee failed to develop a complete individual activity plan (IAP) for one of one resident (R6) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care license. R6's diagnoses include vascular dementia (problems with reasoning, planning, judgement,	02170		

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	29188	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02170	Continued From page 45 memory, and other thought processes" unspecified severity without behavior. R6's Social History and Life Pattern Questionnaire dated August 23, 2022, included the following headings: -demographic/life history -leisure/interests/activity (past and current interests) -life pattern behaviors -food and dining preferences -sleeping preferences & habits -patterns of expression & behaviors -sensory profile -my best day. R6's record lacked the following required content: -current abilities and skills -physical abilities and limitations -adaptations necessary for the resident to participate. On June 27, 2023, at approximately 1:30 p.m., clinical nurse supervisor (CNS)-C gave the surveyor a piece of paper which had R6's name on it and included R6's activities of daily living needs (ADLs). CNS-C had written "MC (memory care) Care Plan for" R6 and drawn arrows to: -interests: attends exercise class, rosary, enjoys watching TV, orange activity bin -redirection: listen to music, color, reminisce. On June 27, 2023, at 1:34 p.m., community life coordinator (CLC)-H stated, "I was told I had to make a calendar (activity), it is so small down there (spaces on the calendar) to include everyone." On June 28, 2023, at 8:00 a.m., licensed assisted living director (LALD)-A stated activity plans did	02170		

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02170	Continued From page 46 not include all the required content. LALD-A said the same form is used for all residents in the secured unit. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of cleaning supplies. 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 June 26, 2023, at 1:45 p.m., the surveyor observed licensed practical nurse (LPN)-E in the	02310		

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02310	Continued From page 47 secured unit performing wound care for R5 in his room. LPN-E walked over to a dresser positioned near the bathroom door in R5's room and picked up an "alcohol prep" pad from an opened box sitting on top of the dresser. The surveyor observed an opened box of alcohol prep pads stacked on an unopened box of alcohol pads. On June 27, at 9:46 a.m., clinical nurse supervisor (CNS)-C said the alcohol prep pads should have been stored in a locked area. CNS-C stated "I tell them [staff] if they [residents] could eat it should be locked up. CNS-C added there are two residents that wander in the secure unit. Drug Facts printed on the alcohol prep pads dated "expired November, 2022", noted: -active ingredient: isopropyl alcohol 70% -warning, for external use only: -flammable, keep away from fire or flame -do not use with electrocautery procedures or in the eyes -stop use if redness or irritation develops discontinue use and consult a physician -keep out of reach of children. Safety Data Sheet, Medline Sterile Alcohol Prep Pads dated May 5, 2022, noted: -causes eye irritation -flammable liquid and vapor -may be harmful if swallowed -may cause an allergic skin reaction No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *06/26/23*
Time: 11:00:55
Report: 1041231032

Food and Beverage Establishment Inspection Report

Location:
Fairway Pines Senior Living
606 Main Street North
Sauk Centre, MN56378
Stearns County, 73

Establishment Info:
ID #: 0039227
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203514900
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

IN THE WALK-IN COOLER, EGGS WERE STORED ABOVE BREAD. STORE EGGS BELOW BREAD TO PREVENT CROSS-CONTAMINATION.

Comply By: 06/27/23

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

AT TIME OF INSPECTION, CHLORINE MEASURED 0 PPM IN THE DISHWASHER. UNTIL DISHWASHER IS REPAIRED, USE 3 COMPARTMENT SINK FOR SANITIZING.

Comply By: 06/27/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

PROVIDE CHLORINE TEST STRIPS TO MEASURE CHLORINE IN DISHWASHER.

Comply By: 07/04/23

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

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

MICHELLE KROONTJE HAD TAKEN THE SERVSAFE CLASS BUT NEVER APPLIED FOR THE STATE CERTIFICATE. SHE WILL RETAKE THE CLASS AND APPLY FOR THE STATE CERTIFICATE.

Comply By: 09/29/23

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.

REMOVE CROCKPOT FROM KITCHEN. IT IS NOT APPROVED EQUIPMENT.

Comply By: 06/27/23

Surface and Equipment Sanitizers

Chlorine: = 0 PPM at Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Hot Holding
Temperature: 142 Degrees Fahrenheit - Location: HAMBURGERS
Violation Issued: No

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

Type: Full
Date: *06/26/23*
Time: 11:00:55
Report: 1041231032
Fairway Pines Senior Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1041231032 of 06/26/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Establishment Representative

Signed: Linda Heinen

Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us

Report #: 1041231032

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud

No. of RF/PHI Categories Out	3	**Date**	06/26/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:00:55
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Fairway Pines Senior Living	606 Main Street North	Sauk Centre, MN	56378	3203514900

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
0039227		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 06/27/23

Inspector (Signature) Linda Hinen