DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 22, 2023

Licensee
The Terraces Assisted Living
901 Feltl Court
Hopkins, MN 55343

RE: Project Number(s) SL22139015

Dear Licensee:

On September 21, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 28, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

PMB

Electronically Delivered

July 17, 2023

Licensee
The Terraces Assisted Living
901 Feltl Court
Hopkins, MN 55343

RE: Project Number(s) SL22139015

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.

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 . . ."

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

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

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

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

REQUESTING A HEARING

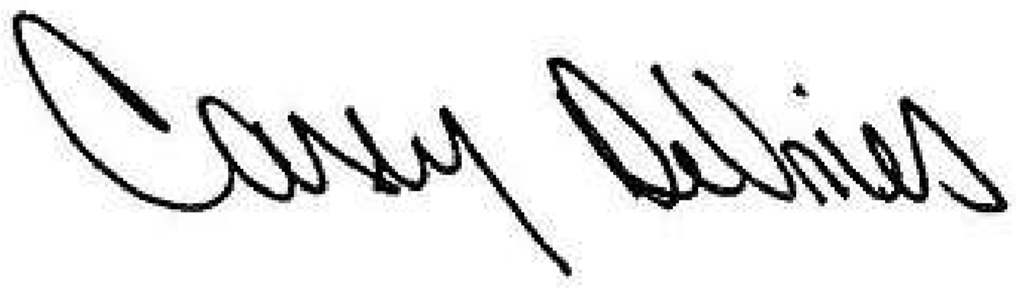
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22139	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES ASSISTED LIVING	901 FELTL COURT HOPKINS, MN 55343

(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: SL22139015-0 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 83 active residents, all of whom received services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving, hand hygiene, and catheter care for two of four employees (unlicensed personnel (ULP)-D, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on March 2, 2017, under the former comprehensive license and started providing assisted living services August 1, 2021.	0 510		

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0 510	Continued From page 2 On June 27, 2023, from 7:15 a.m. to 8:05 a.m., during continuous observation, the surveyor observed ULP-D perform hand hygiene and then apply clean gloves prior to beginning cares on R9. ULP-D assisted R9 out of bed via pivot transfer to wheelchair and then assisted R9 to the bathroom to perform morning oral cares. Without performing hand hygiene or glove removal, ULP-D assisted R9 to the toilet via pivot transfer and utilization of handrails. Assistance with perineal cares was provided at this time. The surveyor observed ULP-D remove dirty gloves and without performing hand hygiene applied clean gloves. The surveyor then observed ULP-D tidy R9's room. Upon completion of morning ADLs, the surveyor observed ULP-D remove dirty gloves and then perform hand hygiene at the sink. On June 27, 2023, at 8:10 a.m., ULP-D stated they were trained to perform hand hygiene after resident cares were performed and that training was completed under nursing supervision. ULP-H ULP-H started employment with licensee November 21, 2013, under the former comprehensive license and started providing assisted living services August 1, 2021. On June 27, 2023, at 11:30 a.m., the surveyor observed ULP-H assist R4 to empty catheter bag contents before going for lunch. ULP-H sanitized hands and donned (applied) gloves before collecting male urinal and alcohol swabs. ULP-H placed the male urinal on the floor next to the R4's foot, opened the alcohol swab then reached for the catheter bag draining tip, cleaned the draining tip and placed the alcohol swab on the floor before emptying the catheter bag contents	0 510		

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0 510	Continued From page 3 into the urinal. On June 27, 2023, at 11:45 a.m., the surveyor observed ULP-H assist R5 to empty catheter bag contents before going for lunch. ULP-H sanitized hands and donned gloves before collecting male urinal and alcohol swabs. ULP-H placed the male urinal on the floor next to the R5's foot, opened the alcohol swab then reached for the catheter bag draining tip, cleaned the draining tip and placed the alcohol swab on the floor before emptying the catheter bag contents into the urinal. On June 27, 2023, at 11:52 a.m., ULP-H stated they should have placed the urinal on a paper towel and grabbed the trash can before starting to give cares to throw the alcohol swab after using it. On June 28, 2023, at 11:04 a.m., clinical nurse supervisor (CNS)-A stated throwing alcohol swabs on the floor spreads germs. Also stated ULP are given procedures to follow when emptying catheter bags. The licensee's Urinary Catheters training manual indicated: - use alcohol wipes to clean ends of tubing/junction sites, and drainage spouts; - drain urine into toilet; - pour warm soapy water or vinegar/water (1:3) solution into drainage bag and shake to get all inside surfaces of bag. Leave in for 20 minutes or overnight; - hang in shower to dry- make sure tube does not touch floor; and - drain and rinse out back with warm water. The Centers for Disease Control's (CDC), "CDC's	0 510		

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0 510	Continued From page 4 Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.2 (a,c,d,e,f) reads: 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. The licensee's undated Hand Hygiene policy, read, " When Hands Should be Washed? Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client d. After removing gloves or gowns e. Before eating and after using a restroom " No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 5 (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 interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for one of two unlicensed personnel (ULP)-D). 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:	0 660		

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0 660	Continued From page 6 The Facility TB Risk Assessment dated May 4, 2023, identified the facility was at a low risk for transmission. ULP-D was hired on March 2, 2017, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-D's employee record included a Baseline TB Screening Tool dated February 7, 2023, Tuberculin skin test (TST) first step dated February 7, 2023, and results read February 9, 2023, indicated positive. ULP-D's record lacked a chest x-ray after positive TB test. Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA. On June 27, 2023, at 10:40 a.m., clinical nurse supervisor (CNS)-A acknowledged ULP-D's record included positive Tuberculin skin test (TST) and no evidence chest x-ray was completed. CNS-A they were told ULP-D's chest x-ray was negative and was waiting on a hard copy. On June 27, 2023, at 4:09 p.m., CNS-A stated ULP-D completed chest x-ray and they were not able to secure hard copy. The licensee's TB Prevention and Control policy dated July 23, 2021, indicated this agency will establish and maintain a TB prevention and	0 660		

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0 660	Continued From page 7 control program based on the most current guidelines issued by the CDC. The Minnesota Department of Health guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings (see 06-009) will be followed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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	0 800		

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0 800	Continued From page 8 the residents). Findings include: On a facility tour on June 27, 2023, at approximately 12:00 p.m. with director of maintenance (DM)-F, it was observed a toilet tank fill valve was running and would not turn off. Plumbing fixtures are required to be maintained as designed and installed. On the same tour it was observed a portable air conditioner was plugged into an extension cord and daisy chained to a multi plug electrical adapter and then to an electrical outlet. Electrical appliances such as air conditioners are required to be plugged directly into an electrical wall outlet in accordance with manufactures instructions. A missing ceiling tile was observed in the corridor of the dementia care unit caused by a leak that had been repaired on a domestic hot water line. The ceiling tiles are required to be maintained as originally designed and installed. The floor finish material around the floor drains in the laundry room on second and third floor were observed with damage to the floor finish exposing the sub-floor underneath. Waterproof finished floor coverings are required to be maintained as designed and installed in order to prevent leakage and damage to the floor below. These deficient conditions were visually verified by DM-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 820	Continued From page 9	0 820		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to affect a limited number of 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on June 27, 2023, at approximately 11:30 a.m. with director of maintenance (DM)-F, it was observed an exterior exit gate leading from a marked exit door in the	0 820		

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0 820	Continued From page 10 secure outdoor patio area was provided with a cable and padlock and a magnetic lock that was not working properly at the time of survey. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors and release to open in one operation. The magnetic lock is required to fail safe in the open position upon loss of power or activation of fire alarm or fire sprinkler system. It was also observed an exterior gate leading from a marked exit door to the public way out of the training room on first floor was provided with a fence type gate latch on the outside of the gate. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors and release to open in one operation. This deficient condition was verified by DM-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22139	A. BUILDING: _____ B. WING _____	06/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES ASSISTED LIVING	901 FELTL COURT HOPKINS, MN 55343

(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
0 970	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 27, 2023, at 11:20 a.m., clinical nurse supervisor (CNS)-A provided the surveyor a blank assisted living contract and stated the contract was used for all licensee's residents. The contract provided indicated in section 24.0 - Personal Property "Facility is not responsible for any loss or damage to resident's personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond Facility's control." On June 30, 2023, at 8:12 a.m., through email correspondence, licensed assisted living director (LALD)-C indicated "this contract was amended in August, 2022 to remove the Waiver of Liability (Indemnification) paragraph which had been Section 29 of the contract. Section 24 relates to personal property."	0 970		

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THE TERRACES ASSISTED LIVING	901 FELTL COURT HOPKINS, MN 55343

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0 970	Continued From page 12 The licensee's policy titled "Contents of Resident Contract" dated January 30, 2023, under subsection 15 stated, "The contract does not include a waiver of facility liability for the health and safety or personal property of a resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01420 SS=D	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 interview and record review, the licensee failed to develop and document instructions for the delegated tasks in the resident's record for one of one resident (R4). This practice resulted in a level two violation (a	01420		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	22139	A. BUILDING: _____ B. WING _____	06/28/2023

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THE TERRACES ASSISTED LIVING	901 FELTL COURT HOPKINS, MN 55343

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01420	Continued From page 13 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: R4 admitted for assisted living services on June 1, 2023. R4's diagnoses included hearing loss, degenerative arthritis, cellulitis, and osteomyelitis. R4's Service Plan dated May 31, 2023, indicated R4 received the following services: medication administration, personal cares, bath, escorts, resident review and assessment. R4's nursing assessment dated June 6, 2023, under section bowel and bladder indicated R4 had a foley care. R4's Service Checkoff List dated June 2023, indicated R4 was receiving assistance with emptying and cleaning urine bag daily. R4's record lacked the following content: - written statement of the delegated task to provide; - written instructions for each delegated task; - any resident-specific requirements relating to documentation of the services received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 28, 2023, at 11:46 a.m., clinical nurse supervisor (CNS)-A stated R4's record was	01420		

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01420	Continued From page 14 missing instructions for the delegated tasks. CNS-A further stated was not sure why it had not been done because it is a requirement. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated licensee's RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01420		
01880 SS=F	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	01880		

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	22139	A. BUILDING: _____ B. WING _____	06/28/2023

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01880	Continued From page 15 by: Based on observation, interview, and record review, the licensee failed to monitor a medication refrigerator to maintain medications according to the manufacturer's directions. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 27, 2023, at 12:45 p.m., the surveyor observed locked medication refrigerator with registered nurse (RN)-H. A thermometer inside the medication refrigerator was confirmed by RN-H to be 20 degrees Fahrenheit (F.). The medication refrigerator contained: - one unpenned box of Humalog Kwik-Pen (short acting insulin) pens, contained three unopen pens; and - one unopened box Lantus Solostar (long-acting insulin) box, contained five flex pens. Manufacturer storage directions for Humalog Kwik pen revised April 2020, indicated, "Unused Pens store in the refrigerator at 36°F to 46°F (2°C [degrees Celsius] to 8°C). Do not freeze your insulin. Do not use if it has been frozen. Unused pens may be used until the expiration date printed on the label, if the pen has been kept in the refrigerator."	01880		

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01880	Continued From page 16 Manufacturer storage directions for Lantus insulin glargine injection dated August 2022, indicated, "Unused pens store in the refrigerator at 36°F to 46°F (2°C to 8°C). Do not freeze your insulin. Do not use if it has been frozen. Unused pens may be used until the expiration date printed on the label, if the pen has been kept in the refrigerator." On June 27, 2023, at 12:45 p.m., RN-H stated night shift staff were supposed to check and monitor the medication refrigerator daily and enter the temperatures into the log to ensure the temperature was in the recommended range, however, she was unable to retrieve the information. The licensee Storage of Medications policy dated July 28, 2021, indicated RN will identify where the medications will be stored, how they will be stored or locked under proper temperature controls. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Type: Full
Date: *06/27/23*
Time: 12:30:00
Report: 1025231149

Food and Beverage Establishment Inspection Report

Location:
The Terraces Assisted Living
901 Feltl Court
Hopkins, MN55343
Hennepin County, 27

Establishment Info:
ID #: 0037711
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9529605555
ID #:

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

No NEW orders were issued during this inspection.

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

Establishment uses contracted service for food
Hennepin County
Undine Corp
835970
3/16/23

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 1025231149 of 06/27/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

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