Electronically Delivered

March 7, 2023

Licensee
Engel Haus
5101 Kassel Avenue Northeast
Albertville, MN 55301

RE: Project Number(s) SL30893015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 14, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

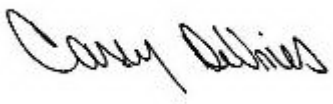
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30893	A. BUILDING: _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGEL HAUS	5101 KASSEL AVENUE NE ALBERTVILLE, MN 55301

(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: SL30893015-0 On February 13, 2023, through February 14, 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 63 active residents; 50 of whom were receiving 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 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 according to the Minnesota Food Code. 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, 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated February 13, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 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 facility 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 and hand hygiene for one of four 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: On February 14, 2023, from 8:00 a.m. to 8:17 a.m., the evaluator observed ULP-D enter R9's apartment, perform hand hygiene, and don clean gloves. ULP-D assisted R9 from the bed to the bathroom and assisted with toileting, including removal of an incontinence brief. The evaluator observed the brief to be soiled with urine. ULP-D placed the soiled brief on the bathroom counter on top of clean incontinence products while ULP-D obtained a garbage bag from a bathroom	0 510		

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0 510	Continued From page 3	0 510		

drawer. Without removing the soiled gloves or performing hand hygiene, ULP-D placed the soiled incontinence brief in garbage bag, then proceed to wash R9's body, and provide peri care. Without removing the soiled gloves or performing hand hygiene, ULP-D assisted R9 with dressing. ULP-D removed the soiled gloves, and without preforming hand hygiene assisted R9 with oral cares and brushing hair, then performed hand hygiene.

On February 14, 2023, at 8:23 a.m., ULP-D stated the staff were trained to wash hands for 30 seconds before and after assisting a resident, and staff should make sure garbage's have garbage bags prior to assisting with cares.

On February 14, 2023, at 12:49 p.m., registered nurse (RN)-B stated staff were trained to perform hand hygiene "between every patient, and when hands are visibly soiled. They need to wear gloves for giving eye drops or if they will be touching medications, or when performing incontinence cares of course, and once they wash the [resident's] bottom they should change gloves, and always clean them [resident] from top down never bottom to top."

The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 30, 2020, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, immediately after glove removal, and when hands were visibly soiled.

The licensee's Hand Hygiene - Assisted Living policy dated June 1, 2022, reads, "When Hands Should be Washed. Hand washing shall be

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0 510	Continued From page 4 performed between resident cares whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: 1. Before and after direct contact with a resident 2. If moving from a contaminated-body site to a clean-body site during resident care 3. After contact with environmental surfaces or equipment in the immediate vicinity of the resident 4. After removing gloves or gowns 5. Before eating and after using a restroom" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 5 orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living 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 licensee's emergency disaster preparedness plan lacked evidence of the following required content: - subsistence needs for staff and residents including emergency lighting; - roles under a wavier declared by secretary; - arrangements with other facilities; and - emergency officials contact information including Minnesota Office of Ombudsman for Long Term Care (OOLTC).	0 680		

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0 680	Continued From page 6 On February 14, 2023, at 9:12 a.m., the evaluator reviewed the EPP with licensed assisted living director (LALD)-A who verified the content listed above was not in the EPP. LALD-A stated contents listed above could potentially be in the computer system and were not printed for the EPP binder. On February 14, 2023, at 11:03 a.m., LALD-A provided the evaluator with documents LALD-A printed from the computer for the EPP, however, the contents of the documents lacked the information listed above. In addition, LALD-A stated the licensee had a plan for emergency lighting however, they did not have documentation to show the licensee's plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment,	0 800		

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0 800	Continued From page 7 including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition 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: On a facility tour on February 15, 2023, at approximately 11:15 a.m. with director of maintenance (M)-H and maintenance (M)-I, it was observed the marked exterior exit door leading from the lounge in the bistro area was unable to fully open because it was contacting the exterior landing. These marked exit doors are required to be available for immediate use for exiting as designed. On the same tour it was observed the marked exterior exit door near the fireplace leading from the dining room was unable to fully open because it was contacting the exterior landing. These marked exit doors are required to be available for immediate use for exiting as designed. It was also observed the exterior exit path was not maintained clear of snow leading from the marked exterior exit door from the bistro area and the marked exterior exit door near the fireplace in	0 800		

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0 800	Continued From page 8 the dining room. Keeping this exterior exit path and the exterior door landings clear of ice and snow helps provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. These deficient conditions were visually verified by M-H and M-I accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The	0 810		

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0 810	Continued From page 9 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 develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. 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). A record review and interview were conducted on February 15, 2023, at approximately 10:15 a.m. of documents provided by director (LALD)-A, director of maintenance (M)-H and maintenance (M)-I on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include:	0 810		

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0 810	Continued From page 10 Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows: Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents in the event of a fire or similar emergency. All deficiencies were verified by LALD-A, M-H and M-I during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date 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,	01640		

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01640	Continued From page 11	01640		

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 provide all services according to the service plan for one of four residents (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).

The findings include:

R2's diagnoses included vascular dementia without behavioral disturbances, diabetes mellitus, and venous insufficiency.

R2's Service Agreement signed July 20, 2022, indicated R2 received services which included assistance with dressing, grooming, toileting, bathing, diabetic management, medication management, and transfer assist of one person with T-belt (transfer/gait belt) to move from one surface to another.

R2's Service Check Off dated February 1, 2023, through February 28, 2023, indicated R2 received transfer assistance with one personnel and a T-belt from February 4, 2023, to February 15,

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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
01640	Continued From page 12 2023. On February 14, 2023, at 8:00 a.m., the evaluator observed unlicensed personnel (ULP)-G attempt to transfer R2 without use of T-belt. The evaluator asked ULP-G if she should be using the T-belt, located in the front basket of R2's walker, for assisting R2 with transfers. ULP-G stated they should have used a T-belt however, forgot it. On February 14, 2023, at 12:45 p.m., registered nurse (RN)-B stated she always expected the ULPs to follow the residents plan of care and always use a T-belt when assisting with transfers and notify the nurse with changes in condition. The licensee's Contents of Service Plans policy dated January 1, 2014, indicated staff providing services would be informed of the current written service plan via a communication method determined by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30893	A. BUILDING: _____ B. WING _____	02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGEL HAUS	5101 KASSEL AVENUE NE ALBERTVILLE, MN 55301

(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
01760	Continued From page 13 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 medication was administered as prescribed for two of ten residents (R6, 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 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: R6 R6 was admitted to the licensee October 1, 2020, and started receiving assisted living services August 1, 2021. R6's Service Agreement signed February 7, 2023, indicated R6 resided in memory care and received assistance with bathing, safety checks, dressing, grooming, vital signs, housekeeping, laundry, medication administration, and toileting. R6's Medication Administration Record (MAR) dated February 1, 2023, through February 28, 2023, included nystatin - triamcinolone cream (a medication used to treat fungal skin infections), apply topically to affected areas twice a day and	01760		

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01760	Continued From page 14 apply to red areas in skin folds for yeast under breast and /or abdomen. On February 14, 2023, at 7:23 a.m., the evaluator observed unlicensed personnel (ULP)-E apply nystatin-triamcinolone cream to R6's buttock. On February 14, 2023, at 7:26 a.m., ULP-E stated the electronic medication administration record (EMAR) indicated cream [nystatin - triamcinolone cream] was to be applied to red areas in skin folds. The evaluator inquired what areas they would apply the cream to. ULP-E stated, "If we see redness that is where we apply." On February 14, 2023, at 11:33 a.m., registered nurse (RN)-B stated specific medication related instructions would be located on the EMAR. In addition, RN-B stated staff did not always open the EMAR to show full instructions on how to administer medication. RN-B stated R6's medication was intended for R6's abdominal folds and under the breasts as indicated on R6's MAR. R7 R7 was admitted to the licensee December 12, 2018, and started receiving assisted living services August 1, 2021. R7's Service Agreement signed February 6, 2023, indicated R7 resided in memory care and received assistance with bathing, behavior management, meals, housekeeping, laundry, medication administration, diabetic management, and safety checks. R7's MAR dated February 1, 2023, through February 28, 2023, included Basaglar Kwikpen (a long-acting insulin), inject 32 units (U)	01760		

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	30893	A. BUILDING: _____ B. WING _____	02/14/2023

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01760	Continued From page 15 subcutaneously once daily, may self-administer with cues and supervision. On February 14, 2023, at 8:08 a.m., the evaluator observed ULP-E dial 32 units of Basaglar without priming insulin pen with two units prior to dialing the prescribed dose, and then provided insulin pen to R7 for self-administration. On February 14, 2023, at 8:16 a.m., ULP-E stated they were trained on medication and insulin administration at orientation and then received a competency from a RN at the facility. In addition, ULP-E stated they were trained to prime and insulin pen however, "I think I just forgot to prime." On February 14, 2023, at 9:28 a.m., RN-B stated staff were trained on medication and insulin administration in a medication class and then completed a competency at the facility. In addition, RN-B stated staff were trained to waste two units of insulin and then dial up the insulin pen to prescribed dose. The licensee's undated procedure for insulin pen administration titled Competency for Insulin Pen indicated staff would prime insulin pen by dialing 2 U of insulin, then while holding pen upright, push the end of the pen to push out the 2 U of insulin. The licensee's Administration of Medication, Treatment, and Therapy by Unlicensed Personnel policy dated March 15, 2022, indicated medications, treatments and therapy always need to be administered according to the "6 Rights": - right person; - right medication, treatment or therapy; - right time;	01760		

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	30893	A. BUILDING: _____ B. WING _____	02/14/2023

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01760	Continued From page 16 - right route; - right dose; and - right chart / record to document that the medication, treatment, and therapy was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for one of one resident (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 situation has occurred only occasionally). The findings include: On February 14, 2023, at 11:30 a.m., the	01880		

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01880	Continued From page 17 evaluator observed the assisted living refrigerator with registered nurse (RN)-C which contained various medications for multiple residents including bisacodyl suppositories (rectal medication) for pain and constipation for R8. The manufacturer's guidelines for bisacodyl suppository dated November 15, 2016, recommended to store it at room temperature and away from excess heat and moisture. On February 14, 2023, at 11:30 a.m., RN-C stated they were not aware the suppositories were to be stored at room temperature, would call the pharmacy to consult with them about the storage of the suppository medication, and then store the medication as they recommend. The licensee's Medication Management Services policy dated May 1, 2022, indicated the RN will develop an individualized medication management plan for the resident. The plan will address: -Description of how medications managed by our facility will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions (i.e., need for refrigeration). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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	01890		

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01890	Continued From page 18 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 discard expired medication for three of ten residents (R5, R6, R7) and failed to ensure time sensitive medications were labeled with the date opened for one of ten residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: EXPIRED MEDICATIONS On February 14, 2023, at 7:34 a.m., the evaluator observed R6's medication cabinet and observed the following expired medications: - Genteal Tears lubricating solution eye drops with an expiration date of January 2021; and - triamcinolone acetonide ointment 0.1 percent (%) with an expiration date of August 2022. Unlicensed personnel (ULP)-E stated it was the nurse's responsibility to remove expired medications from the medication cabinets during cycle fill (when a pharmacy automatically sends resident's medications to a facility on a regular basis).	01890		

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01890	Continued From page 19 On February 14, 2023, at 7:42 a.m., the evaluator observed R5's medication cabinet and observed the following expired medications: - acetaminophen 500 milligram (mg) tablets with an expiration date of January 2022; and - triple antibiotic ointment + pain relief with an expiration date of May 2021. ULP-E stated R5 no longer received the medications listed above. On February 14, 2023, at 8:08 a.m., the evaluator observed R7's medication cabinet and observed polyethylene glycol 3350 gram (G) with an expiration date of July 2022. On February 14, 2023, at 7:52 a.m., registered nurse (RN)-B stated expired medications should be removed from the resident's medication cabinet when nursing refilled cabinet with medications after they received cycle fill every two weeks. In addition, RN-B stated if the ULP notices an expired medication they were trained to give the expired medication to the nurse. TIME SENSITIVE MEDICATIONS On February 14, 2023, at 8:08 a.m., ULP-E provided the evaluator with a Basaglar Kwikpen and Novolog FlexPen from R7's medication cabinet and stated, "no one labeled it." ULP-E stated the licensee trained them to date insulin with date open labels once opened. The evaluator observed the following time sensitive medications were opened without a date open label: - one opened Basaglar Kwikpen; and - one opened Novolog FlexPen. On February 14, 2023, at 9:28 a.m., RN-B stated staff are trained to date insulin pens once used.	01890		

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01890	Continued From page 20 The manufacturer's instructions for Basaglar KwikPen dated November 2022 recommended Basaglar KwikPen be discarded 28 days after opening. The manufacturer's instructions for Novolog FlexPen dated January 2019 recommended Novolog FlexPens be discarded 28 days after opening. The licensee's undated procedure for insulin pen administration titled Competency for Insulin Pen indicated staff would check the expiration date of the insulin pen prior to administration of insulin. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for one of one resident (R1) who utilized oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02310		

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02310	Continued From page 21 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 February 13, 2023, at 10:41 a.m., during the facility tour, the evaluator observed one unsecured oxygen cylinder standing upright on the floor, and not secured to prevent tipping in R1's apartment. On February 14, 2023, at 8:55 a.m., the evaluator observed one concentrator, one oxygen cylinder in a wheeled oxygen cart, and three unsecured oxygen cylinders standing upright on the floor, and not secured to prevent tipping in R1's apartment. On February 14, 2023, at 2:10 p.m., registered nurse (RN)-B stated "Staff are trained to make sure all tanks are secured. I know I get so mad at the oxygen company because they try to bring me the oxygen tanks without a holder, and I tell them take it back or bring me a holder. So, I always make them bring me a holder. Though now, I thought you were able to lay them down and put them under the bed." Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided.	02310		

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02310	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP) followed appropriate medication administration procedures for one of three employees (ULP-G), observed 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) 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 February 14, 2023, from 6:45 a.m. through 8:15 a.m., the evaluator observed ULP-G provide morning cares and medication administration. ULP-G provided cares for two other residents	02320		

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02320	Continued From page 23 before entering R8's room. At 8:00 a.m., ULP-G pulled an unlabeled envelope out of their pocket and stated the envelope contained a Morphine 2.5 mg tablet for R8. ULP-G proceeded to complete R8's morning medication pass to include the Morphine 2.5mg tablet. On February 14, 2023, at 11:15 a.m., ULP-G stated all resident narcotics were stored in a central storage area, and all resident non-narcotic medications were stored in locked cabinet in their rooms. ULP-G stated she had been trained by another ULP to start the day by getting any narcotics to be administered on that shift, putting them in an envelope, and putting the envelope in her pocket before starting any resident care. The licensee's Administration of Medication, Treatment, and Therapy by Unlicensed Personnel policy dated May 1, 2022, indicated ULPs would be trained and competency tested by the RN on preparation and administration of the medication to the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *02/13/23*
Time: 12:34:11
Report: 7989231034

Food and Beverage Establishment Inspection Report

Location:
Engel Haus
5101 Kassel Avenue Ne
Albertville, MN55301
Wright County, 86

Establishment Info:
ID #: 0039347
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634984594
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.

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

REPLACE THE CRACKED AND TORN DOOR GASKETS ON THE SMALL FREEZER ON THE COOKLINE

Comply By: 03/13/23

Surface and Equipment Sanitizers

Acid: = 272 at Degrees Fahrenheit
Location: PREP
Violation Issued: No

Hot Water: = at 176 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 172 Degrees Fahrenheit - Location: POT PIE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 156 Degrees Fahrenheit - Location: QUICHE
Violation Issued: No

Type: Full
Date: *02/13/23*
Time: 12:34:11
Report: 7989231034
Engel Haus

Food and Beverage Establishment Inspection Report

Process/Item: Prep Cooler
Temperature: 36 Degrees Fahrenheit - Location: HAM LUNCH MEAT
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 41 Degrees Fahrenheit - Location: HAM
Violation Issued: No

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

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

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 7989231034 of 02/13/23.

Certified Food Protection Manager: BRIAN BRANTNER

Certification Number: 31274 Expires: 06/28/24

Signed: _____
Establishment Representative

Signed: Tyffani Maresh

Tyffani Maresh
Public Health Sanitarian
St Cloud
320-223-7361
Tyffani.Maresh@state.mn.us

Report #: 7989231034

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, & Lodging Section
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	02/13/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:34:11
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Engel Haus	5101 Kassel Avenue Ne	Albertville, MN	55301	7634984594

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039347		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		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:** 02/13/23

Inspector (Signature) Tyffani Marcel