Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 12, 2023

Licensee
Legacy Care Home
5531 Eden Prairie Road
Minnetonka, MN 55345

RE: Project Number(s) SL33588015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 31, 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 . . ."

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,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 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
	33588	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY CARE HOME	5531 EDEN PRAIRIE ROAD MINNETONKA, MN 55345

(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: SL33588015-0 On August 28, 2023, through August 31, 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 seven (7) current residents, all of whom received 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 with Dementia Care licensed 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 had the potential to affect all residents of the assisted living facility. 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 August 28, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510		

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0 510	Continued From page 2 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 and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for 1 of 2 employees (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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired January 6, 2023, and provided direct care services for residents. On August 28, 2023, at 11:11 a.m., ULP-D was observed to check blood glucose and administer insulin to R3. ULP-D was already wearing gloves at the beginning of the observation. ULP-D checked R3's blood glucose (BG) level, then attached a needle to the insulin pen and	0 510		

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0 510	Continued From page 3 administered insulin. ULP-D disposed of sharps and garbage. Without removing the soiled gloves or performing hand hygiene, ULP-D returned the supplies to the medication storage closet, removed gloves, then performed HH, using soap and water, for five seconds. On August 28, 2023, at 11:27 a.m., ULP-D stated he had infection control training. ULP-D stated he could not remember how long to perform HH, but "guessed two minutes and 1 1/2 minutes." ULP-D added he never really counted. On August 28, 2023, at 11:55 a.m., licensed assisted living director and clinical nursing supervisor (LALD/CNS)-A stated HH training was included in infection control training for staff, and staff were trained to perform HH for 20 seconds if using soap and water. LALD/CNS-A stated they did not officially document HH audits, but that staff did get HH training annually. The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated, standard precautions were to be used to care for all patients (residents) in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices 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	0 510		

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0 510	Continued From page 4 contaminated surfaces f. Immediately after glove removal." The licensee's 8.09 Handwashing policy, dated August 1, 2021, indicated, "When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves." The policy further indicated the steps for proper hand washing included, "5. Use friction and scrub vigorously for at least 20 seconds (long enough to sing 'Happy Birthday' twice)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in	0 780		

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0 780	Continued From page 5 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected so actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 facility tour with Assistant Director (AD)-F on August 30, 2023, at approximately 10:00 a.m., it was observed that upon testing, the smoke alarms in the sleeping rooms were not interconnected to the smoke alarms in the other sleeping rooms in the facility so that the actuation of one smoke alarm would cause all other alarms in the facility to actuate. These deficient conditions were visually verified by AD-F accompanying the tour.	0 780		

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0 780	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or 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 August 30, 2023, at approximately 10:00 a.m., survey staff toured the facility with Assistant	0 800		

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0 800	Continued From page 7 Director (AD)-F. During the facility tour, survey staff observed the following: In the outdoor resident activity space, it was observed that the metal fence enclosures and the fence posts were swaying and were not securely anchored to the concrete slab. The deck was elevated from the adjacent yard and was part of the emergency egress route from the living room. In resident bedrooms #5, #6, and #7, it was observed that the door lever lock was installed on the outside of the bedroom door. When the lever lock was lowered, the room was locked from the outside, and the resident could exit the room from inside. During the interview, AD-F stated that the lever lock was stalled to limit any wandering residents entering the room but verified this deficient lever lock condition. During the facility tour interview, AD-F visually verified these deficient findings at the time of discovery. No further information was provided. 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;	0 810		

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0 810	Continued From page 8 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide a maintained fire safety and evacuation plan that showed the location and number of resident rooms; failed to provide fire protection procedures necessary for residents, failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.	0 810		

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0 810	Continued From page 9 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: An interview and record review were conducted on August 30, 2023, at approximately 12:00 p.m., with assistant director (AD)-F on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. On the facility tour with AD-F, it was observed that the posted fire safety plan and evacuation plan did not have the number of resident rooms. This deficient condition was visually verified by AD-F accompanying the tour. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview, AD-F verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that employees did not receive training twice per year after initial hire. Employee training records were requested, and no training records were provided. During the interview, AD-F stated that the staff training record would be provided via	0 810		

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0 810	Continued From page 10 email as a follow-up. Review of the follow-up email received from assisted living director in residency (ALD)-B on August 31, 2023, ALD-B provided only one staff training on fire safety and evacuation conducted July 13, 2023. No further information was provided. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Review of the provided documented drills indicated that the licensee had conducted fire drills on March 22, 202,3 at 2:30 p.m., April 14, 2023, at 4:00 p.m., and May 2, 2023, at 11:30 p.m. During the interview, AD-F stated that the additional fire drill record would be provided via email as a follow-up. Review of the follow-up email received from ALD-B on August 31, 2023, ALD-B provided only one additional fire drill record conducted on July 14, 2023 at 1:30 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	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	0 820		

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0 820	Continued From page 11 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. The licensee had door lock hardware that required a code to exit the home on the egress side of all the doors leading outside. This had the potential to affect all current 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 the potential to affect a large portion or all of the residents). On August 30, 2023, at approximately 10:00 a.m., survey staff toured the facility with Assistant Director (AD)-F. During the facility tour, survey staff observed the following: The main entrance door, the door to the outdoor activity space from the living room, and the door to the outdoor activity space from the sunroom were identified as egress exit doors on the fire safety and evacuation plan. But all those three doors had a lock that required a code to exit. During the interview, AD-F verified that the locks were not tied to the building fire alarm or sprinkler system and would not default to an unlocked	0 820		

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0 820	Continued From page 12 (fail-safe) position if the power went out. The locks in the path of egress that require a code would cause a delay in the proper exiting of the home during a fire or similar emergency. AD-F visually verified this deficient finding during the facility tour and stated that he was working with a consultant to resolve the lock issue. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not 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 provider orders and manufacturer recommendations for one of three residents observed for medication administration	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33588	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY CARE HOME	5531 EDEN PRAIRIE ROAD MINNETONKA, MN 55345

(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 (R3). 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: R3's service plan dated May 19, 2023, indicated R3 received services including assistance with blood glucose monitoring and medication management. R3's record included a prescriber order dated May 26, 2023, directed to administer NovoLog insulin pen (insulin aspart, a fast-acting insulin) 100 units per milliliter (u/ml), 3 units (U) subcutaneously three times daily. R3's medication administration record (MAR) for August 2023, indicated R3 was administered NovoLog insulin pen100 u/ml 3U three times daily, from August 1 through August 29, 2023. On August 28, 2023, at 11:11 a.m., unlicensed personnel (ULP)-D was observed to check R3's blood glucose (BG) level. ULP-D, without accessing the medication administration record (MAR) or R3's orders, placed a needle on the novolog insulin pen. ULP-D then asked R3 how much insulin he took. R3 stated he took 4U. ULP-D, without first priming the insulin pen, dialed the pen to "4" and administered 4U of insulin. ULP-D documented the insulin was administered, under the scheduled, "NovoLog	01760		

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	33588	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY CARE HOME	5531 EDEN PRAIRIE ROAD MINNETONKA, MN 55345

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01760	Continued From page 14 pen 100 u/ml Inject 3 units subcutaneously 3 times daily for diabetes". On August 28, 2023, at 11:15 a.m., ULP-D stated the MAR indicated to administer 3U. ULP-D stated he gave 4U because that was the amount R3 would take. ULP-D further stated he had not been trained to prime the insulin pen prior to administering insulin. On August 28, 2023, at 11:23 a.m., licensed assisted living director and clinical nursing supervisor (LALD/CNS)-A stated ULP were trained to perform the six "rights" of medication administration. LALD/CNS-A stated R3's provider (prescriber) had given verbal permission to administer 4U of insulin per R3's request when R3 refused to take 3U. On August 28, 2023, at 11:55 a.m., LALD/CNS-A stated the provider verified the order should have been for 3U of insulin. LALD/CNS-A stated she should have instructed the ULP to talk to her first and she should then have obtained a verbal one time order from the provider to administer 4U, if necessary. LALD/CNS further stated the priming instruction provided to ULP was to produce a droplet of insulin at the tip of the needle before administering the ordered dose. LALD/CNS-A added they planned to update the policy and ULP training to include priming the insulin pen with 2U before they administered the prescribed dose. NovoLog insulin user instructions dated November 2021, indicated before each injection with the NovoLog insulin pen, "To avoid injecting air and to ensure proper dosing", the user perform an "air shot" by turning the dose knob to two (2) units, holding the pen vertical with the needle pointing up, and pushing the dose knob	01760		

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	33588	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY CARE HOME	5531 EDEN PRAIRIE ROAD MINNETONKA, MN 55345

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01760	Continued From page 15 until it stops. The instructions indicated if a droplet of medication was not visible at the tip of the needle, the needle be changed, and the action repeated, up to six times until a droplet of medication was visible at the tip of the needle. The licensee's 7.36 Insulin policy dated August 1, 2021, indicated, "Insulin medications must be administered according to the prescriber's orders." The policy further indicated the steps of insulin administration included, "Confirm accuracy of dose with prescriber order." No further information 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, including the opened date for time sensitive medication storage for one of two residents (R3). 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33588	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 16 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: R3's service plan dated May 19, 2023, indicated R3 received services including assistance with medication management. R3's medication administration record (MAR) for August 2023, indicated R3 was administered NovoLog insulin pen (insulin aspart, a fast-acting insulin) daily from August 1 through August 29, 2023. On August 28, 2023, at 11:45 a.m., the surveyor observed R3's medication storage contained one opened NovoLog insulin pen. The pen lacked a label to indicate the date staff first used the insulin and when the insulin would expire. ULP-D stated it was not his practice to date the pen when he opened it. On August 28, 2023, at 11:55 a.m., licensed assisted living director and clinical nursing supervisor (LALD/CNS)-A stated ULP were trained to date insulin pens when they were opened. LALD/CNS-A further stated she had been reinforcing with staff the importance of dating the insulin pens as well as eye drops upon opening. The manufacturer's instructions for the use of the NovoLog insulin pen dated November 2021, indicated the opened NovoLog insulin pen would be stored at room temperature only, and should be discarded after 28 days.	01890		

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	33588	A. BUILDING: _____ B. WING _____	08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 17 The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications would be stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility and failed to provide any mitigation factors for any of the hazards associated with the physical environment. This deficient practice had the ability 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	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33588	A. BUILDING: _____ B. WING _____	08/31/2023

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02040	Continued From page 18 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 of the available documentation and interview was conducted on August 30, 2023, at approximately 12:00 p.m. with Assistant Director (AD)-F on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had an emergency plan with identified hazards but did not perform a hazard vulnerability assessment or safety risk assessment on and around the property nor prescribed any mitigation factors for any of the hazards associated with the physical environment. During the interview, AD-F verified that there were no further documents for the hazard vulnerability assessment and mitigation factors and verified this deficient condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

DEPARTMENT OF HEALTH

Type: Full
Date: *08/28/23*
Time: 11:56:49
Report: 1036231210

Food and Beverage Establishment Inspection Report

Location:
Legacy Care Home
5531 Eden Prairie Road
Minnetonka, MN55345
Hennepin County, 27

Establishment Info:
ID #: 0037654
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6129648376
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.

4-700 Sanitizing Equipment and Utensils

4-703.11C ***** Priority 1 *****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

THERE WAS NO SANITIZING STEP AFTER MANUAL WASHING DISHES AND UTENSILS. OPERATORS SET UP A SANITIZING BUCKET AND MDH DEMONSTRATED PROPER WASHING, RINSING, AND SANITIZING OF UTENSILS.

Comply By: 08/28/23

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.

NO CHLORINE TEST STRIPS ON SITE FOR MEASURING CONCENTRATION OF SANITIZING BUCKET. MDH PROVIDED A FEW TEST STRIPS UNTIL SOME CAN BE OBTAINED.

Comply By: 09/04/23

2-300 Personal Cleanliness

2-301.12C

MN Rule 4626.0070C Food employees must avoid recontamination of their hands after handwashing by using a disposable paper towel or similar clean barrier to close faucet handles on a handwashing sink or the handle on a restroom door.

OBSERVED EMPLOYEE WASH HANDS THEN TURN OFF FAUCET WITH BARE HANDS BEFORE DRYING. MDH REVIEWED PROPER HANDWASHING TECHNIQUES WITH STAFF.

Type: Full
Date: *08/28/23*
Time: 11:56:49
Report: 1036231210
Legacy Care Home

Food and Beverage Establishment Inspection Report

Comply By: 08/28/23

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/SOUR CREAM
Temperature: 39 Degrees Fahrenheit - Location: ARCTIC AIR COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: ARCTIC AIR COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -1 Degrees Fahrenheit - Location: AVANTCO SINGLE DOOR REACH IN FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS RENEE ANDERSON. INSPECTION CONDUCTED WITH CFPM STEPHANIE FRYER ALONG WITH JULIO AND ROBYN.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- SANITIZER USE AND TEST KITS.
- HAND WASHING POLICY AND REVIEW.
- NO BARE HAND CONTACT WITH RTE FOOD.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.

THE FACILITY HAS A DISH MACHINE BUT IT IS CURRENTLY NOT OPERATING. UNTIL THE DISH MACHINE IS REPAIRED, DISHES ARE DONE MANUALLY AND MUST UTILIZE A 3 COMPARTMENT SINK METHOD OF WASHING, RINSING, AND UTILIZING A BUCKET WITH CHLORINE FOR SANITIZING. THE FACILITY HAS A DESIGNATED SINK FOR HANDWASHING ONLY.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER

SYMPTOMS HAVE ENDED.

**IF ANY RESIDENTS OR STAFF COMPLAIN OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036231210 of 08/28/23.

Certified Food Protection Manager: Stephanie L. Fryer

Certification Number: FM109271 Expires: 01/26/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Stephanie Fryer
Kitchen Manager

Signed: _____
Jeff Johanson