Electronically Delivered

March 14, 2024

Licensee
Heritage Court Assisted Living
110 South Henderson Street
Houston, MN 55943

RE: Project Number(s) SL20339015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, 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.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. 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 appeal.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	20339		02/22/2024

NAME OF PROVIDER OR SUPPLIER

HERITAGE COURT ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE

110 SOUTH HENDERSON STREET
HOUSTON, MN 55943

(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: SL20339015-0 On February 20, 2024, through February 22, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 20 residents; 19 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is	0 100		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Minnesota Department of Health

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0 100	Continued From page 1 licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	0 100		

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0 100	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to obtain accurate licensure when they applied for licensure for an assisted living facility, despite sharing one roof with an adjoining clinic in the same building, without having an approved two-hour fire wall. 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: The licensee's health facility identification (HFID) 20339 was located at 110 Henderson Street Houston Minnesota (MN) 55943 and was attached to 511 East Maple Street Houston MN 55943 by a shared interior wall as leased space and not part of the licensed assisted living facility. On February 22, 2024, at 10:30 a.m., Minnesota department of Health (MDH) environmental engineer (EE) survey staff toured the facility with director of maintenance (DM)-E. During the tour, EE survey staff observed the following: 1. The swing-style door leading into the clinic from the licensed assisted living facility had a 20-minute fire door label. DM-E verified the 20-minute fire door label during the facility tour interview. 2. The swing-style door leading into the employee break room (labeled as a board room	0 100		

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0 100	Continued From page 3 on the fire evacuation floor plan) from the licensed assisted living facility had a 20-minute fire door label. DM-E explained during the facility tour interview, that this break room was for clinic employees and not part of the licensed assisted living facility. DM-E verified the 20-minute fire door label during the facility tour interview. During an interview on February 22, 2024, at 11:45 a.m. with licensed assisted living director (LALD)-A, EE survey staff stated assisted living licensing required the wall separating licensed assisted living facilities from another licensed facility or another occupancy in the same building to be constructed as a 2-hour fire barrier wall. LALD-A stated the clinic was a leased space and not part of the licensed assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 100		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health,	0 250		

Minnesota Department of Health

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0 250	Continued From page 4 safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation	0 250		

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0 250	Continued From page 5 by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 20, 2024, at 12:00 p.m., licensed assisted living director (LALD)-A, clinical nurse supervisor (CNS)-B, and housing manager (HM)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page five and six of the application), identified, I certify I have read	0 250		

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0 250	Continued From page 6 and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in	0 250		

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0 250	Continued From page 7 some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and	0 250		

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0 250	Continued From page 8 procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by LALD-A on May 25, 2023. The licensee had an assisted living license issued on July 1, 2023, with an expiration date of June 30, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) orientation, training, and competency evaluations of staff; (2) handling complaints regarding staff or services provided by staff; (3) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional; (4) medication management; (5) delegation of tasks by registered nurses or licensed health professionals; (6) supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0550, 1370, 1380, 1440, 1500, 1620, 1770, 1790, and 1910, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

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0 550	Continued From page 9	0 550		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content as well as the required information related to the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect the licensee's 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, but was not likely to cause serious injury, impairment, or death), and	0 550		

Minnesota Department of Health

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0 550	Continued From page 10 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 lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. Though the posting included information for the Office of Ombudsman for Long-Term Care, it did not include the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. On February 20, 2024, at 1:05 p.m. during facility tour with housing manager (HM)-C, the surveyor observed the licensee's grievance procedure posted on the bulletin board near the resident mailboxes. However, the posted information lacked the above content as required. On February 20, 2024, at 1:10 p.m. HM-C stated the content was not included on the grievance procedure as required. The licensee's Complaint policy dated April 25, 2022, noted the written notice included: d. The name and contact information of the person representing the facility designated to handle and resolve complaints. e. The contact information for the Office of Ombudsman for Long-term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. No additional information was provided.	0 550		

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0 550	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 640		

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110 SOUTH HENDERSON STREET
HOUSTON, MN 55943

(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
0 640	Continued From page 12 portion or all of the residents). The findings include: On February 20, 2024, at 1:05 p.m. the surveyor toured the facility with housing manager (HM)-C. The facility was observed to be lacking a posting of the MAARC hotline number in the common areas of the facility. On February 20, 2024, at 1:12 p.m. HM-C stated the MAARC hotline number was not posted in the facility as required. The licensee's Assisted Living Required Postings and Disclosure policy dated April 29, 2022, included postings required at all times: 5. Minnesota (MN) Adult Abuse Reporting Center information and reporting number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (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;	0 680		

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0 680	Continued From page 13 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the licensee's 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: On February 20, 2024, at 1:05 p.m. during the facility tour with housing manager (HM)-C, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted.	0 680		

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0 680	Continued From page 14 On February 20, 2024, at 1:14 p.m. HM-C stated the plan was not posted prominently and was not aware of the requirement. The licensee's Assisted Living Required Postings and Disclosure policy dated April 29, 2022, included postings required at all times: 2. Emergency Disaster Plan (prominently). No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the	0 730		

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0 730	Continued From page 15 resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (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, 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).	0 730		

Minnesota Department of Health

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0 730	Continued From page 16 The findings include: R3's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R3's record contained a nurse progress note dated September 22, 2023, at 11:09 a.m. that indicated the resident was discharged to a skilled nursing facility for long term care. However, the summary lacked the above required content. On February 20, 2024, at 1:49 p.m. clinical nurse supervisor (CNS)-B stated a discharge summary had not been completed other than making an entry in the progress notes. CNS-B stated she was not aware of the discharge summary component requirements indicting she hadn't done that for any discharged residents. The licensee's Discharge Summary policy dated April 25, 2022, noted a discharge summary would be written by the time of discharge. The discharge summary would include, if applicable: a. Summary of the resident's stay that including i. Diagnoses ii. Course of illnesses iii. Allergies iv. Treatments v. Therapies	0 730		

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0 730	Continued From page 17 vi. Pertinent lab results vii. Pertinent radiology results viii. Pertinent consultation results ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral, and functional status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
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 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,	0 780		

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0 780	Continued From page 18 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 interconnected smoke alarms that complied with fire protection requirements. 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 the potential to affect a large portion or all of the residents). The findings include: On February 22, 2024, at 10:30 a.m., survey staff toured the facility with director of maintenance (DM)-E. During the tour, survey staff observed when smoke alarms were tested in resident apartments 101, 103, 104, 108, 111, 112, and 116 none of the other smoke alarms in the dwelling unit were activated. The smoke alarms installed in the bedrooms and outside each sleeping area were not interconnected. On February 22, 2024, during the facility tour interview, DM-E verified the smoke alarms were not interconnected. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		

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0 800	Continued From page 19	0 800		
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 provide 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, 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). The findings include: On February 22, 2024, at 10:30 a.m., survey staff toured the facility with director of maintenance (DM)-E. During the tour, survey staff observed the following: 1. The spring hinges installed on the 20-minute fire doors leading from the corridor into the resident dwelling units were not working properly, these doors did not self-close and positively latch.	0 800		

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0 800	Continued From page 20 This was observed for resident apartments 101, 103, 104, 108, 111, 112, and 116. All components of a fire door assembly must be maintained in proper working order. On February 22, 2024, during the facility tour interview, DM-E verified these doors did not self-close stated these spring hinges had been adjusted per the resident's request. 2. Twenty-minute fire doors were held open by wedges in the employee lounge and office. 3. The one-hour fire door was held open by a kick down door stop for the laundry room. Propping fire doors in the open position prohibits the required operation and closing feature of the door. On February 22, 2024, during the facility tour interview, DM-E verified the fire doors were not maintained properly. 4. In resident apartment 103, a power strip was plugged into another power strip. Overloading power strips can create a potential fire hazard. On February 22, 2024, during the facility tour interview, DM-E verified these power strips were being used improperly and stated they were not aware this. 5. The cover for the light fixture was missing in the bedroom closet of resident apartment 104. On February 22, 2024, during the facility tour interview, DM-E verified the light cover was missing. 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:	0 810		

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0 810	Continued From page 21 (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 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 record review and interview, the licensee failed to provide required training and drills. 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	0 810		

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0 810	Continued From page 22 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 the residents). The findings include: On February 22, 2024, director of maintenance (DM)-E, housing manager (HM)-C, and licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation to support this training had been completed. One training record was provided for an employee in-service training on fire safety and rescue dated 2018. Records indicated FSEP training was scheduled for November 2024. No additional training records were provided. During an interview with survey staff on February 22, 2024, at 1:50 p.m., licensed assisted living director (LALD)-A verified the frequency was not met for employee training on the facility FSEP. LALD-A stated employees completed fire safety and evacuation training offered by an online training provider. Survey staff explained the statute requires employees to complete training on the facility FSEP. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill	0 810		

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0 810	Continued From page 23 every other month as evident by fire drill reports lacking the required frequency. One employee fire drill report was recorded in January 2023, conducted at 10:00 a.m. During an interview with survey staff on February 22, 2024, at 1:50 p.m., licensed assisted living director (LALD)-A verified the licensee had not completed the required number of evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a	0 950		

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0 950	Continued From page 24 designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for the right to a designated representative on a document separate from the contract and failed to ensure the contract included the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Assisted Living Contract was signed by housing manager (HM)-C and R1's responsible party on January 9, 2024. R2's Assisted Living Contract was signed by HM-C and R2's responsible party on December 6, 2023. The first page of R1 and R2's Assisted Living Contract: Summary & Contact Information contained the following paragraph: A Designated Representative is someone who may not have legal authority to act on behalf of a	0 950		

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0 950	Continued From page 25 resident but who has been identified by a resident as having authority to receive information and notices about the resident specifically related to the resident's health condition. Although having a Designated Representative can be helpful to both resident and the facility, resident is not obligated to identify such a person. Below the paragraph was a box to check and a line for a designated representative to be named with address and telephone number. In addition, there was another box to checkmark if resident declined to identify a Designated Representative and a line for the resident to initial. R1 and R2's records lacked evidence in writing of providing the verbatim notice on a document separate from the contract as required. On February 21, 2024, at 11:31 a.m. HM-C stated R1 and R2's contract and record lacked the required content as listed above. In addition, HM-C stated the licensee's contract would lack the same content for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	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		

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0 970	Continued From page 26 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 one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee's Assisted Living Contract: Terms & Conditions included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. 23. Indemnification, page 12 of the contract, "As an occupant of [Licensee name], Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will indemnify and hold harmless Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in party by, an act or omission of Resident or Resident's guests or agents."	0 970		

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0 970	Continued From page 27 25. Liability, page 13 of the contract, "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents. Provider is also not liable for any injury, death or damage occurring as the result of Resident's receipt of health-related, supportive or other services from third-party providers. Unless caused by one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment or on Provider's premises." On February 21, 2024, at 11:31 a.m. housing manager (HM)-C stated these clauses are included in the contract, and the same contract was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains,	01060		

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01060	Continued From page 28 at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for	01060		

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01060	Continued From page 29 one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 began receiving assisted living services on January 16, 2024. R1's [The Licensee's] Nursing Care Points form (identified as the the service plan) dated January 16, 2024, indicated R1 received services including dressing, grooming, bathing, toileting, transferring, and medication administration. R1's nurse progress notes dated January 27, 2024, at 9:20 a.m. indicated R1 was admitted to the hospital after requesting to be taken to the emergency room via ambulance for severe pain in her left leg. Nurse progress notes dated January 30, 2024, at 3:07 p.m. identified R1 returned from the hospital with new medication orders. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation. - the name and contact information for the location to which the resident has been relocated and any new service provider. - contact information for the Office of Ombudsman for Long-Term Care. - if known and applicable, the approximate date	01060		

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01060	Continued From page 30 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On February 20, 2024, at 2:03 p.m. clinical nurse supervisor (CNS)-B stated no written notice was provided to R1. CNS-B stated she was not aware of the emergent relocation regulation. The licensee's Contract Termination policy dated April 29, 2022, included: 8B. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: 1. The reason for the relocation; 2. The name and contact information for the location to which the resident has been relocated and any new service provider; 3. Contact information for the Office of Ombudsman for Long-Term Care; 4. If known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and 5. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility will provide contact information for the agency to which the resident may submit an appeal. 6. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative;	01060		

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01060	Continued From page 31 b. For residents who receive home and community-based waiver services under the resident's case manager; and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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01370	Continued From page 32 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of one employee (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: ULP-D was hired on October 26, 2021, to provide direct care services to residents at the assisted living. ULP-D's record lacked evidence the following	01370		

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01370	Continued From page 33 competencies had been completed prior to providing direct cares: -appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; -standby assistance techniques and how to perform them; On February 22, 2024, at 1:24 p.m. housing manager (HM)-C stated the above topics were lacking from ULP-D's employee file. The licensee's Assisted Living Orientation-ULP Staff policy dated April 27, 2022, identified in addition to training all staff receive, ULP who are not a registered nursing assistant would receive additional training with a written or oral competency test and a skill demonstration on the above missing topics. The licensee's Personnel Records policy dated revised April 27, 2022, noted a personnel record for each person will include: c. Record of all required training for unlicensed personnel and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	01380		

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01380	Continued From page 34 competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure training and competency evaluations contained all the required training for one of one 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: ULP-D was hired on October 26, 2021, to provide direct care services to residents at the assisted living.	01380		

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01380	Continued From page 35 ULP-D's employee record lacked evidence to indicate the employee's completed practical skills evaluations as required in the following areas prior to providing direct care services: -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On February 22, 2024, at 1:24 p.m. housing manager (HM)-C stated the above topics were lacking from ULP-D's employee file. The licensee's Assisted Living Orientation-ULP Staff policy dated April 27, 2022, identified in addition to training all staff receive, ULP who are not a registered nursing assistant would receive additional training with a written or oral competency test and a skill demonstration on the above missing topics. The licensee's Personnel Records policy dated April 27, 2022, noted a personnel record for each person will include: c. Record of all required training for unlicensed personnel and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440		

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01440	Continued From page 36 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one 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).	01440		

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01440	Continued From page 37 The findings include: ULP-D was hired on October 26, 2021, to provide direct care services to residents at the assisted living. ULP-D's employee record lacked documentation of a RN supervising ULP-D performing delegated tasks within 30 days of beginning work with the licensee. On February 21, 2024, at 8:24 a.m. ULP-D was observed administering R1's scheduled morning medications. On February 22, 2024, at 1:25 p.m. housing manager (HM)-C stated she could not find evidence of a 30-day supervisory review for ULP-D. The licensee's Supervision of Unlicensed Personnel policy dated April 27, 2022, noted direct supervision of staff performing delegated tasks would be provided within 30 days after the individual began working for the provider and had been trained and determined competent to perform all the tasks assigned. After the initial period of direct supervision, the RN and/or licensed health professional will determine the frequency of ongoing, additional direct supervision based on the individual staff person's performance and on the needs and condition of individual residents, the types of services being provided and the experience of the staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01500	Continued From page 38	01500		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 39 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C started employment on October 26, 2021.	01500		

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01500	Continued From page 40 ULP-C's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: -infection control techniques; and -review of the facility's policies and procedures. On February 22, 2024, at 1:23 p.m. housing manager (HM)-C stated ULP-D's file lacked the above required annual training. The licensee's Annual Training policy dated April 27, 2022, noted all assisted living employees will complete annual education on the following topics: b. assisted living bill of rights; g. review of policies and procedures relating to the provision of assisted living services and how to implement them; No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620		

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	20339		02/22/2024

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01620	Continued From page 41 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed 14 days from admission for one of two 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 start of care was December 6, 2023, with diagnosis of intercostal (rib cage) pain. R2's [The Licensee's] Nursing Care Points form (identified as the the service plan) dated December 6, 2023, indicated R2 received	01620		

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01620	Continued From page 42 services including bathing assistance and medication administration. R2's record included an admission assessment dated December 6, 2023, and a 14-day assessment dated December 22, 2023. The 14-day assessment was 16 days after the date of the admission assessment, exceeding the 14 calendar days. On February 22, 2024, at 9:00 a.m. clinical nurse supervisor (CNS)-B stated R2's 14-day assessment was late. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated April 29, 2024, noted nursing assessments are completed by a registered nurse based upon the required assessment schedule as required: b. 14-day assessment: completed up to 14-days after start of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident;	01650		

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01650	Continued From page 43 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included all the required content for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1's diagnosis included hypertensive heart failure	01650		

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01650	Continued From page 44 (heart is unable to pump enough blood to the body due to high blood pressure). R1's [The Licensee's] Nursing Care Points form (identified as the the service plan) dated January 16, 2024, indicated R1 received services including dressing, grooming, bathing, toileting, transferring, and medication administration. On February 21, 2024, at 8:24 a.m. unlicensed personnel (ULP)-D was observed administering R1's scheduled morning medications. R2 R2's diagnosis included intercostal (rib cage) pain. R2' [The Licensee's] Nursing Care Points form dated December 6, 2023, indicated R2 received services including bathing and medication administration. On February 21, 2024, at 11:08 a.m. ULP-D was observed to offer R2's eye ointment in which resident refused. R1 and R2's service plan lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650		

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01650	Continued From page 45 and -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On February 21, 2024, at 11:15 a.m. housing manager (HM)-C stated the content was lacking on the service plan as noted above and was the same format utilized for all residents. The licensee's Contents of Service Plans policy dated April 29, 2022, noted the service plan would include: -schedule and methods of monitoring assessments; -schedule and methods of monitoring staff providing services; and -contingency plan that includes: -action taken if the scheduled service cannot be provided; -names and contact information of persons the resident wishes to have notified in an emergency; -names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition; -identification of and information on who has authority to sign for the resident in an emergency; and -circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		

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01770	Continued From page 46	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R4's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. During the entrance conference on February 20, 2024, at 12:00 p.m. clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication setup. R4's [The Licensee's] Nursing Care Points form	01770		

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01770	Continued From page 47 (identified as the service plan) dated June 12, 2023, indicated R4 received weekly medication set up. On February 21, 2024, at 1:25 p.m. clinical nurse supervisor (CNS)-B stated she completed a medication set-up for R4. CNS-B stated she followed R4's medication list/prescriber orders for the medication set-up and documented that a medication set-up had been completed. However, CNS-B stated she did not document the name of the medication, quantity of dose, times to be administered, or route of administration anywhere in R4's record, or for anyone else getting a medication set up. CNS-B further stated she was not aware of the requirement. The licensee's Medication Management Services policy dated December 20, 2022, lacked direction specific to medication set-up. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days ,	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the	01790		

Minnesota Department of Health

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01790	Continued From page 48 medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;	01790		

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01790	Continued From page 49 (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for one of one employee (unlicensed personnel (ULP)-D) providing medications for residents with unplanned time away from home when the licensed nurse was not available. 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 included: ULP-D was hired on October 26, 2021, to provide direct care services to residents at the assisted living. ULP-D's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home.	01790		

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01790	Continued From page 50 On February 22, 2024, at 1:30 p.m. housing manager (HM)-C stated ULP-D was trained to administer medications and would encounter times when she would need to get medications ready for a resident to take with them for unplanned time away. HM-C stated they did not do any formal competency for any staff preparing medications for residents with unplanned time away indicating ULP-D's employee record lacked the above required competency. The licensee's Delegation of Medications to be Given to Residents by Unlicensed Staff for Residents Time Away from Home policy dated April 29, 2022, noted only unlicensed staff that have been trained and have satisfactorily demonstrated competency will be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed 7 days of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications	01910		

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01910	Continued From page 51 remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the prescription numbers as applicable, for one of one discharged resident (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, 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: The licensee's discharged resident roster dated February 20, 2024, indicated R3 discharged on October 11, 2023, to another facility. R3's [The Licensee's] Nursing Care Points form (identified as the service plan) dated August 15, 2023, indicated R3 received services including	01910		

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01910	Continued From page 52 medication administration for three or less medication times daily. R3's Active Medications (identified as the form used for the disposition of medications) dated September 22, 2023, identified the medication name/strength, dosing route, dosing instructions, amount remaining, initials of staff and signature of individuals involved in the disposition. The document indicated medications were sent to the new facility with R3. The document did not include the prescription numbers for the prescriptions as applicable. - The following medications were listed without a prescription number: dorzolamide/timolol (for high eye pressure), duloxetine (antidepressant), hydroxycholor (for arthritis), latanoprost (for high eye pressure), levothryoxine (for hypothyroidism), and prednisone (corticosteroid). On February 20, 2024, at 1:49 p.m. clinical nurse supervisor (CNS)-B stated she had completed R3's disposition of medications using an active medication report sheet and had failed to include the prescription numbers. CNS-B further indicated this was not the form or process for disposition of medications anymore. The licensee's Disposition or Disposal of Medication policy dated April 29, 2022, noted staff would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. This policy did not direct to include the prescription numbers as applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01910		

Minnesota Department of Health

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01910	Continued From page 53 days	01910		

MDH
EH-FPLS
18 Wood Lake Dr
Rochester
507-206-2700

Type: Full
Date: *02/21/24*
Time: 14:40:06
Report: 1045241033

Food and Beverage Establishment Inspection Report

Location:
Heritage Court Assisted Living
110 Henderson Street
Houston, MN55943
Houston County, 28

Establishment Info:
ID #: 0038272
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5078963125
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.

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40F Degrees Fahrenheit - Location: Upright - Ambient
Violation Issued: No

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

Firm serves approximately 19 meal plans daily to their assisted living residents. The meals are prepped in the nursing home commercial kitchen and delivered to the serving kitchen located off of the dining space. Meals are delivered and served in about 45min.

Limited items stored in the residential refrigerator. Utilize this space for non potentially hazardous food storage only (ie.. store diary, meats and cut leafy greens or items in the commercial refrigeration units within the main preparation kitchen)

Type: Full
Date: *02/21/24*
Time: 14:40:06
Report: 1045241033
Heritage Court Assisted Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MDH inspection report number 1045241033 of 02/21/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Amanda Langheinrich
Housing Director

Signed:_____
Nicole Hunger
Public Health Sanitarian
Rochester District Office
nicole.hunger@state.mn.us

Report #: 1045241033

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MDH
EH-FPLS
18 Wood Lake Dr
Rochester

No. of RF/PHI Categories Out	0	Date	02/21/24
No. of Repeat RF/PHI Categories Out	0	Time In	14:40:06
Legal Authority MN Rules Chapter 4626		Time Out	

Heritage Court Assisted Living	Address	City/State	Zip Code	Telephone
	110 Henderson Street	Houston, MN	55943	5078963125

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038272		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
Surpervision				
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		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:** 02/22/24

Inspector (Signature)