Electronically Delivered

December 29, 2022

Licensee
Boulder Ponds Senior Living
192 Jade Trail North
Lake Elmo, MN 55042

RE: Project Number(s) SL37071015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 1, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
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Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37071	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULDER PONDS SENIOR LIVING	192 JADE TRAIL NORTH LAKE ELMO, MN 55042

(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 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: SL37071015 On November 29, through December 1, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 72 residents, with 67 receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 30, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for one of five residents (R4) when unlicensed personnel (ULP)-G, a mandated reporter, was aware of signs of potential abuse but failed report them to the Minnesota Adult Abuse Reporting Center (MAARC) or a person in charge per the licensee's policy. 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).	0 620		

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0 620	Continued From page 3 The findings include: On November 30, 2022, at approximately 8:30 a.m., ULP-G dressed R4. The surveyor observed four (4) bruises on R4's left outer thigh in the shape of fingerprints with additional bruising extending toward top of thigh in the shape of fingers. ULP-G applied R4's pants, and assisted R4 to roll to R4's right side. ULP-G placed their right hand in the same manner and placement of the four bruises and pulled R4 to their right. ULP-G did not question R4 about bruising source or impact on R4. ULP-G proceeded to complete cares and left R4's room. ULP-G stated they were done working with R4 and needed to complete cares in other residents' rooms. On November 30, 2022, at approximately 9:15 a.m., licensed assisted living director (LALD)-D, registered nurse (RN)-A, and executive director (ED)-E, stated they were not aware of any bruising on R4. LALD-D stated the expectation per the licensee's policy is all suspected signs of abuse would be reported to a RN or to administration team immediately. On December 1, 2022, at approximately 11:00 a.m., LALD-D provided Adverse Event Investigation dated November 30, 2022, at 9:15 a.m., and Minnesota Adult Abuse Reporting Center report dated November 30, 2022, at 6:02 p.m. LALD-D stated the licensee's policy for reporting possible abuse to the appropriate parties. The licensee's Vulnerable Adult/Maltreatment - Communication, Prevention, and Reporting (626.557) policy dated August 2019, read, "Employees will report findings, verbally and immediately to their supervisor. The supervisor	0 620		

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0 620	Continued From page 4 will then immediately report to the Administrator and Director of Nursing Services. The Administrator or designee will initiate the investigation. An incident report will be completed." Additionally, the policy read, "Falls, unexplained bruises, and cuts need to be reported to nurse.." (sic) No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers	0 660		

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0 660	Continued From page 5 for Disease Control and Prevention (CDC) which included a history and symptom screening result for one of two employees (unlicensed personnel (ULP)-B). 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-B was hired on October 10, 2022. ULP-B's QuantiFERON-TB Gold Plus (a laboratory test for the presence of TB) results dated September 22, 2022, were negative. ULP-B's record lacked a history and symptom screening as required. On December 1, 2022, at 12:00 p.m., licensed assisted living director (LALD)-D stated ULP-B's history and symptom screening was not in ULP-B's record but was expected to be completed prior to working with residents. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH dated March 1, 2022, did not answer one (1) if a baseline TB screening was completed, question two (2) indicated annual screenings would be completed based on the history and symptom screening lacking from ULP-B's record. No further information provided.	0 660		

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0 660	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had 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 re pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include:	0 790		

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0 790	Continued From page 7 On 11/30/2022, from approximately 10:00 AM to 11:30 AM, survey staff toured the facility with maintenance (M)-F. During the facility tour, survey staff observed that the fire extinguishers throughout the facility did not have a monthly inspection conducted. M-F verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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, 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	01060		

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01060	Continued From page 8 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. 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 to the resident, legal representative, or designated representative for one of one resident (R4) who had an emergency relocation. 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: R4 admitted on August 2, 2021.	01060		

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01060	Continued From page 9 R4's Progress Notes dated October 10, 2022, at 11:29 p.m., indicated R4 sustained a fall resulting in being transported and admitted to a hospital. R4's Progress Notes dated October 13, 2022, at 5:31 p.m., indicated R4 returned from the hospital at 4:00 p.m., that day. R4's record lacked documentation R4 or R4's designated representative was provided an emergency relocation notice with the required content. On December 1, 2022, at 12:00 p.m. licensed assisted living director (LALD)-D stated licensee was not aware of the required content of an emergency relocation notice and licensee had not provided the notice to any resident who required an emergency relocation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility.	01460		

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01460	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided prior to providing assisted living services to residents for one of two employees (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) 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: ULP-C, temporary staff, began working at the licensee's facility in November 2022, to provide direct care services to the licensee's residents. On November 30, 2022, at 9:05 a.m., the surveyor observed ULP-C provide morning cares for R2. ULP-C's record lacked evidence orientation was completed for the following required topics: -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling emergencies and use of emergency services; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and	01460		

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01460	Continued From page 11 service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On December 1, 2022, at 11:35 a.m., licensed assisted living director (LALD)-D stated ULP-C did not receive the required orientation and none of the temporary staff would have the required orientation. The licensee's Master Staffing Agreement document from the staffing agency the licensee contracted with indicated client (the facility) shall orientate healthcare professional (HCP) to their facility, including its rules, regulations, policies, procedures, physical layout, emergency protocol, emergency evacuation and equipment on any unit to which the HCP is assigned, and should include, but is not limited to: tour of unit(s) HCP may work, review of emergency protocol/codes, review of physical payout of facility, documentation, medication administration, review emergency evacuation procedure, equipment to be used by HCP, orientation to policies/procedures, facility specific orientation, and infection control policy.	01460		

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01460	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed the required hours of dementia care training in the required time frame for one of two employees (unlicensed personnel (ULP)-B). 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	01540		

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	37071	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULDER PONDS SENIOR LIVING	192 JADE TRAIL NORTH LAKE ELMO, MN 55042

(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
01540	Continued From page 13 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-B was hired on October 10, 2022. Executive Director (ED)-E stated ULP-B worked 30 hours a week. ULP-B's undated Relias Transcript indicated ULP-B completed one and a half (1.5) hours of dementia related training. ULP-B's required eight (8) hours of dementia related training was due to be completed by October 31, 2022. On December 1, 2022, at 12:00 p.m. licensed assisted living director (LALD)-D stated ULP-B's dementia related training was not completed within the require time frame for the required number of hours. LALD-D indicated ULP-B would be assigned the required training and removed from the schedule until the training was completed. The licensee's Education policy dated April 2022, indicated all staff would complete the licensee's Orientation Packet. The licensee's Orientation Packet indicated dementia training would be completed and documented in the employee record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		

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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 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 resident monitoring and reassessment within the required time frames for one of five residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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01620	Continued From page 15 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: R5 was admitted on July 6, 2021. R5's most recent Annual/Change in Condition Assessment was dated June 28, 2022. R5's next assessment was due September 26, 2022, had the licensee completed the assessment within 90 days as required. On December 1, 2022, at 12:00 p.m., licensed assisted living director (LALD)-D stated R5's assessment was overdue and was an oversight by the registered nurses. LALD-D stated the licensee's expectation is all assessments are completed within 90 days of the previous assessment. The licensee's Comprehensive Assessment Schedule dated August 2022, indicated ongoing client monitoring and reassessment would be completed, "At least every 90 days." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 16 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee or resident to document agreement on the services to be provided for two of five residents (R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	01640		

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01640	Continued From page 17 found to be pervasive). The findings include: R2 R2's signed Service Plan dated October 1, 2022, included services of activities of daily living, meals, escorts, catheter care, CPAP, medication administration, incontinence assistance, transfers with full mechanical lift, transfers sit-to-stand, bed-rail safety check, and turning/repositioning. R2's Service Plan with print date of November 30, 2022, included services of activities of daily living, meals, catheter care, CPAP, medication administration, incontinence assistance, turning/repositioning, transfer assist, ambulation-physical assist of one, and bed-rail safety check initiated on or after October 1, 2022. R2's record lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provide by licensee after addition of services on or after October 1, 2022. R5 R5's Service Addendum to the Assisted Living Contract signed August 30, 2022, indicated R5 received services which included medication assist/admin, TED/compression stocking, and vital signs. R5's Service Addendum to the Assisted Living Contract signed August 30, 2022, identified by licensed assisted living director (LALD)-D as R5's most current service plan. R5's Service Addendum to the Assisted Living Contract with effective date of November 30,	01640		

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01640	Continued From page 18 2022, included ten (10) services with effective dates after August 30, 2022. R5's record lacked a signed service agreement with all current services provided. On December 1, 2022, at approximately 12:00 p.m., LALD-D stated the licensee failed to obtain a signature on the revised service plans for R2 and R5. LALD-D indicated the licensee's practice was to obtain authentication by resident or designated representative with each revision of the service plans. The licensee's Service Plan policy dated April 2022, indicated all service plan revisions would be authenticated by the "home care provider and by the client or the client's representative." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from	03000		

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03000	Continued From page 19 another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the	03000		

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03000	Continued From page 20	03000		

requirements for reporting suspected maltreatment for one of five residents (R4) when unlicensed personnel (ULP)-G, a mandated reporter, was aware of signs of potential abuse but failed report them to the Minnesota Adult Abuse Reporting Center (MAARC) or a person in charge per the licensee's policy.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On November 30, 2022, at approximately 8:30 a.m., ULP-G dressed R4. The surveyor observed four (4) bruises on R4's left outer thigh in the shape of fingerprints with additional bruising extending toward top of thigh in the shape of fingers. ULP-G applied R4's pants, and assisted R4 to roll to R4's right side. ULP-G placed their right hand in the same manner and placement of the four bruises and pulled R4 to their right. ULP-G did not question R4 about bruising source or impact on R4. ULP-G proceeded to complete cares and left R4's room. ULP-G stated they were done working with R4 and needed to complete cares in other residents' rooms.

On November 30, 2022, at approximately 9:15 a.m., licensed assisted living director (LALD)-D, registered nurse (RN)-A, and executive director (ED)-E, stated they were not aware of any bruising on R4. LALD-D stated the expectation

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03000	Continued From page 21 per the licensee's policy is all suspected signs of abuse would be reported to a RN or to administration team immediately. On December 1, 2022, at approximately 11:00 a.m., LALD-D provided Adverse Event Investigation dated November 30, 2022, at 9:15 a.m., and Minnesota Adult Abuse Reporting Center report dated November 30, 2022, at 6:02 p.m. LALD-D stated the licensee's policy for reporting possible abuse to the appropriate parties. The licensee's Vulnerable Adult/Maltreatment - Communication, Prevention, and Reporting (626.557) policy dated August 2019, read, "Employees will report findings, verbally and immediately to their supervisor. The supervisor will then immediately report to the Administrator and Director of Nursing Services. The Administrator or designee will initiate the investigation. An incident report will be completed." Additionally, the policy read, "Falls, unexplained bruises, and cuts need to be reported to nurse.." (sic) No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *11/29/22*
Time: 14:00:17
Report: 1023221244

Food and Beverage Establishment Inspection Report

Location:
Boulder Ponds Senior Living
192 Jade Trail North
Lake Elmo, MN55042
Washington County, 82

Establishment Info:
ID #: 0037673
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124312430
ID #:

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

The following orders were issued during this inspection.

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

OBSERVED TCS FOODS KEPT FOR MORE THAN 8 DAYS. OPERATOR DISCARDED FOOD UPON NOTIFICATION. CHECK PREPARATION DATES AND DISCARD AS NEEDED DAILY.

Comply By: 11/29/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

Hot Water: = at 175 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/FISH
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BUTTER
Temperature: 40 Degrees Fahrenheit - Location: COFFEE COOLER
Violation Issued: No

Type: Full
Date: *11/29/22*
Time: 14:00:17
Report: 1023221244
Boulder Ponds Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/CUT TOMTO
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER #1
Violation Issued: No

Process/Item: Cold Hold/SAUCE
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER #2
Violation Issued: No

Process/Item: Hot Hold/SOUP
Temperature: 147 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION. FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

THIS FACILITY CONSISTS OF A MAIN KITCHEN AREA WITH TYPE I HOOD/ANSUL AND PREP SINK. FOOD SERVICE IS PROVIDED BY A CONTRACTED COMPANY.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FOOD COOLING METHODS
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

ALL FOOD AT THIS ESTABLISHMENT IS FULLY COOKED. THERE IS NO NEED FOR RAW FOOD REMINDER/DISCLOSURE ON RESIDENT MENUS.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023221244 of 11/29/22.

Certified Food Protection Manager: JOSE ZENTELLA

Certification Number: 108506 Expires: 11/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
JOSE ZENTELLA
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259

Food and Beverage Establishment Inspection Report

Gregory T Nelson

greg.nelson@state.mn.us