DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 1, 2022

Administrator
Woodbury Estates
2825 Woodlane Drive
Woodbury, MN 55125

RE: Project Number(s) SL20551015

Dear Administrator:

On January 14, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 22, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

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Electronically Delivered

November 23, 2021

Administrator
Woodbury Estates
2825 Woodlane Drive
Woodbury, MN 55125

RE: Project Number(s) SL20551015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 22, 2021, 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.

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 Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

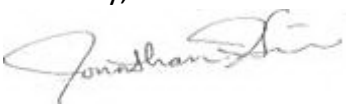
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. 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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
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St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20551	A. BUILDING: _____ B. WING _____	10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY ESTATES	2825 WOODLANE DRIVE WOODBURY, MN 55125

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.93, these correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL20551015 On October 19, 2021, through October 20, 2021, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. At the time of the survey, there were sixty-one (61) residents receiving services under the 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 Home Care 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 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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0 250	Continued From page 1 (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, 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; (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;	0 250		

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0 250	Continued From page 2 (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 by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, had developed and implemented current policies and procedures as required, with records reviewed. 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 October 19, 2021, at approximately 9:30 a.m., licensed assisted living director (LALD)-A confirmed he was responsible for and participated in the day-to-day operations. LALD-A stated they were	0 250		

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0 250	Continued From page 3 familiar with the Assisted Living with Dementia Care licensing rules. The licensee had attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the following orders were issued: Refer to licensing order at Statute 144G.40, Subd 2. The licensee failed to provide a Uniform Checklist Disclosure of Services (UDALSA) to all residents. Refer to licensing order at Statute 144G.42 Subd 6. The licensee failed to provide a written policy or procedure for reporting maltreatment of vulnerable adults. Refer to licensing order at Statute 144G.41, Subd. 1. The licensee failed to develop a staffing plan, as required. Refer to licensing order at Statute 144G.41 Subd. 1. The licensee failed to ensure food was prepared and served according to the Minnesota Food Code. Refer to licensing order at Statute 144G.42, Subd. 6. The licensee failed to ensure an individual abuse prevention plan was developed to include statements of the specific measures to be taken to minimize the risk of abuse. Refer to licensing order at Statute 144G.42 Subd. 7. 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) in common areas and near telephones provided by the	0 250		

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0 250	Continued From page 4 assisted living facility. Refer to licensing order at Statute 144G.43 Subd. 8. The licensee failed to ensure the employee record contained all the required content. Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to develop and maintain a tuberculosis (TB) prevention and control program. Refer to licensing order at Statute 144G.50, Subd. 2 (a). The licensee failed to maintain the physical environment in a continuous state of good repair and operation. Refer to licensing order at Statute 144G.45, Subd. 2. The licensee failed to provide documentation of policy, schedule, and log of staff training for fire, safety, and evacuation procedures. Refer to licensing order at Statute 144G.50, Subd. 1. The licensee failed to develop, implement, and provide a contract containing all required content to all residents. Refer to licensing order at Statute 144G.50, Subd. 3. The licensee failed to ensure all residents were provided the opportunity to designate a representative, as required. Refer to licensing order at Statute 144G.64, (a). The licensee failed to ensure all employees had completed training in dementia care, as required. Refer to licensing order at Statute 144G.70, Subd. 2. The licensee failed to ensure the RN completed assessments of all residents at the frequency required and using the Uniform	0 250		

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0 250	Continued From page 5 Assessment Tool, as required. Refer to licensing order at Statute 144G.70, Subd. 4. The licensee failed to develop and implement a service plan for all residents. Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to ensure each resident receiving medication management services had an individualized medication management plan containing all required content. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed to ensure all required content for disposition of medications was documented in R4's record. Refer to licensing order at Statute 144G.72, Subd. 3. The licensee failed to develop and maintain an individualized therapy management plan for all residents receiving treatments and/or therapies. Refer to licensing order at Statute 144G.81, Sub. 1. The licensee failed to provide the proper documentation that a hazard vulnerability or safety risk assessment had been performed on and around the property. Refer to licensing order at Statute 144G.90, Subd. 1. The licensee failed to provide the current Assisted Living Bill of Rights to all residents. Refer to licensing order at Statute 144G.82 Subd. 2. The licensee failed to ensure the licensed assisted living director (LADL)-A of an assisted living with dementia care completed all required annual continuing education requirements relating to the care of individuals with dementia.	0 250		

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0 250	Continued From page 6 Refer to licensing order at Statute 144.6502, Subd. 8. The licensee failed to ensure required postings notifying visitors of electronic monitoring was posted at facility entrances. Twenty-two (22) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules was limited or not evident for compliance with sections 144G.08 to 144G.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).	0 430		

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0 430	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content for two of three residents (R1, R3) with records reviewed. This had the potential to affect all sixty-one (61) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: R1 and R3's records lacked evidence of a signature from the resident or resident's representative indicating a UDALSA was given at time of admission, to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offered to provide under the assisted living facility contract, and identifying all services allowed under the license the facility does not provide. R1's diagnoses included, but were not limited to, left knee replacement. R1's service plan dated September 28, 2021, indicated R1 received	0 430		

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0 430	Continued From page 8 services which included medication administration, housekeeping, and bathing and grooming assistance. R3's diagnoses included, but were not limited to, dementia and hyponatremia. R3's service plan dated August 4, 2021, indicated R3 received services which included medication administration and assistance with bathing, grooming, and dressing. On October 20, 2021, at approximately 10:55 a.m. the director of marketing (DM)-H indicated R1 and R3 and/or their representatives had not provided a signature indicating they received a UDALSA listing all services provided under the facility's license, as well as the services not provided under the facility's license. DM-H stated R1 had received a UDALSA, but had not provided a signature indicating it was received; and also stated R3 was not able to sign papework and requested several times via email for resident representative to sign the UDALSA indicating that it had been received. DM-H stated she made no other attempts other than email to have R3's UDALSA signed by a representative for R3. The licensee's UDALSA policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 9 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting all of 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	0 470		

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0 470	Continued From page 10 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: The licensee held an assisted living facility with dementia care license. The facility was licensed for a resident capacity of 75 residents and had a current census of 61 residents. During the entrance conference on October 20, 2021, at approximately 9:30 a.m. licensed assisted living director (LALD)-D explained how the facility staffed the buildings as part of the staffing plan and indicated their daily schedule would be considered their staffing plan. LALD-D verified a written staffing plan was not developed. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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	0 480		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 11 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 had the potential to affect all sixty-one (61) clients in the Assisted Living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated October 19, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20551	A. BUILDING: _____ B. WING _____	10/22/2021

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0 630	Continued From page 12 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for 3 of 3 residents (R1, R2, R3) with records reviewed. 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: R1, R2, and R3's records lacked an IAPP which reviewed each resident's susceptibility to abuse by another individual, including other vulnerable adults; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of	0 630		

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0 630	Continued From page 13 abuse to that resident and other vulnerable adults. R1 started services August 27, 2021, and had diagnoses to include dementia and left knee pain. R1's record lacked a vulnerability assessment. R1's service plan dated September 28, 2021, indicated the resident received services which included medication administration, assistance with dressing, grooming, housekeeping, laundry, and bathing. R2 started services September 21, 2021, and had diagnoses to include cerebral infarction (stroke). R2's resident record included a vulnerability assessment dated September 27, 2021, that identified multiple areas of vulnerability including R2 was unable to report abuse or neglect, and was vulnerable to abuse by others. The vulnerability assessment did not identify interventions or specific measures to be taken to minimize R2's risk of abuse. R3 started services August 4, 2021, and had diagnoses to include dementia and hyponatremia. R3's record lacked a vulnerability assessment. R3's unsigned service plan dated August 4, 2021, indicated the resident received services which included medication administration, housekeeping, laundry, assistance with bathing, dressing, grooming, and toileting. On October 20, 2021, at 9:23 a.m. director of nursing (DON)-C verified R2's vulnerability evaluation lacked interventions. DON-C further indicated the vulnerability evaluation for R2 would typically serve as the IAPP and should include	0 630		

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0 630	Continued From page 14 interventions. On October 20, 2021, at 12:20 p.m. director of nursing (DON)-B confirmed IAPPs were not completed for any of the listed residents. The licensee's Individual Abuse Prevention Plan dated July 15, 2021, indicated the facility must develop and implement an IAPP for each vulnerable adult residing or receiving services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640	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 post information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in	0 640		

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0 640	Continued From page 15 common areas and near telephones provided by the assisted living facility. 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: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. In addition, there was no evidence of the contact information or reporting number for MAARC. On October 19, 2021, during the facility tour at approximately 11:00 a.m., the surveyors observed two units' common areas; there was no required posting of the 911 emergency number and the reporting number for MAARC. On October 20, 2021, at approximately 12:45 p.m. Licensed Assisted Living Director (LALD)-A confirmed the 911 emergency number and the reporting number for MAARC were not posted in common areas but stated there was at one time a binder in each area that had the emergency numbers listed. LALD-A stated the binder was not in place. The licensee's policy was requested, but not provided.	0 640		

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0 640	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.	0 650		

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0 650	Continued From page 17 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of two employees (RN-A, ULP-E) with employee records reviewed. 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: Registered nurse (RN)-A had a hire date of September 14, 2021. RN-A's employee record lacked evidence of a signed position description. On October 19, 2021, at 12:57 p.m., licensed assisted living director (LALD)-D indicated a position description for RN-A should be provided. On October 20, 2021, LALD-D provided a position description signed by RN-A on October 19, 2021 (during the survey). Unlicensed personnel (ULP)-E had a hire date of July 26, 2011. ULP-E's record lacked evidence of a performance review completed annually. ULP-E's record included a performance review last completed April 9, 2020. On October 20, 2021, at 11:12 a.m., director of nursing (DON)-B indicated ULP-E has not had a	0 650		

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0 650	Continued From page 18 more current performance evaluation due to leadership turnover and challenges. DON-B stated the licensee was in the process of "getting caught up." The licensee's undated Employee File Guidance policy indicated the employee "Orientation Folder" would contain a signed job description. The policy further indicated the employee "General Review Folder" would contain employee performance reviews. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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:	0 660		

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0 660	Continued From page 19 Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and history/symptom screening for 1 of 2 employees (RN-A) with employee records reviewed. 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 facility TB risk assessment dated June 14, 2021, indicated the facility was a low risk setting for TB transmission. Registered nurse (RN)-A was hired September 14, 2021, and provided direct cares for residents of the facility. RN-A's employee record included documentation of a TB chest x-ray (CXR) with negative results completed July 26, 2021, but did not include the recommended two-step tuberculin skin test (TST), single blood test, or proof of previous positive results. RN-A's employee record did not include a TB history or symptom screening form completed at the time of hire. On October 19, 2021, during a 12:57 p.m. interview, director of nursing (DON)-B stated the	0 660		

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0 660	Continued From page 20 licensee does not require a TST if employees provide a CXR. DON-B verified the TB screening form was not in RN-A's employee file. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's TB infection control plan policy, revised September 2021, indicated, "All HCWs should receive a baseline TB screening upon hire using a two-step TST or single blood test to test for infection with M. tuberculosis." The policy further indicated baseline screening consisting of assessment of current symptoms of active TB disease, assessment of TB history, and testing for presence of TB by administering the two step TST or single blood test was required for all health care workers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 21 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the building tour on October 19, 2021, with the plant operations director (POD) the surveyor observed the following: 1. The emergency exit door out the back of the boiler room was in a state of disrepair. The lintel had a majority of the paint chipped off of it and had rusted in all exposed areas. The wood sill was loose, creating a potential tripping hazard. The metal door had black staining around the edges and patches of rust. Surveyor was not able to determine what the black staining came from. POD said it was from condensation and	0 800		

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0 800	Continued From page 22 suggested the door needed to be cleaned. Outside this door was a shaft. The shaft started at the level of the boiler room floor and went up to the grade level above, approximately eight feet above. Boiler room had fresh air louvers into the shaft. There was a grate secured over the top of the shaft which the surveyor could not see how to open. An exit ladder was bolted into the concrete masonry unit (CMU) wall of the shaft, but the top bolts had come out of the wall and were no longer secured. The shaft wall had a large crack running diagonally across the wall and parts were not plumb suggesting that the wall could collapse under the wrong circumstances and block the boiler room emergency exit. Pieces of the shaft wall had fallen out and the surveyor could see into the space behind the wall. 2. There was water damage and staining on many ceiling tiles throughout the basement. POD stated the fan coil units (FCU) would leak condensation and cause the staining. He lifted the damaged ceiling tiles and the surveyor could see the FCU and the condensation tray directly above the stained ceiling tiles. POD stated they vacuum out the condensation trays multiple times a summer, but the ceilings still get stained from overflowing condensation trays. 3. All the bathroom fans in the surveyed resident rooms had been unplugged. POD stated the residents complain the fan in the bathroom is too loud and they have been unplugging them. Fans are on same switch as the bathroom lights. 4. Public restrooms on first and second floor did not have functioning fans. POD stated the rooftop fans that control the restroom fans are broken and they are waiting on parts to get them repaired.	0 800		

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0 800	Continued From page 23 5. Second floor carpet is taped together in some areas. POD stated the floors are being replaced in phases. Some areas have loose carpet that can be a tripping and fall hazard for residents, visitors, and staff. Second floor is the memory care unit. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

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0 810	Continued From page 24 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 interview and record review, the licensee failed to provide documentation of policy, schedule, and log of staff training for fire safety and evacuation procedures. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 19, 2021, while reviewing records, the surveyor read in the emergency preparedness documents that staff are trained upon hire and annually thereafter. Statute requires staff be trained upon hire and twice per year thereafter. On October 19, 2021, when interviewing POD, he confirmed that they were only doing staff training once per year.	0 810		

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0 810	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.	0 900		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY ESTATES	2825 WOODLANE DRIVE WOODBURY, MN 55125

(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
0 900	Continued From page 26 (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute and give a complete copy of any signed contract and any addendums and all supporting documents and attachments to the resident promptly after a contract and any addendum has been signed for one of three (R1, R2, R3) residents with record reviewed. 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: R3 records lacked a signed written contract which included all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable In addition, resident records lacked evidence the contract had been fully executed as the facility	0 900		

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0 900	Continued From page 27 must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. R3's record lacked a signed service plan; however, R3's undated, unsigned service plan indicated the resident received services which included medication administration, bathing, transferring, dressing, grooming/hygiene, toileting/incontinence management, housekeeping and laundry. R3's record lacked any indication that R3 had been given the option to choose a designated representative. The section of the record indicating who is chosen as the representative or if the resident refused to designate was left blank. On October 20, 2021, at approximately 10:55 a.m., the director of marketing (DM)-H was not sure if R3 was given the option to choose a designated representative or decline. Director of marketing DM-H stated R3 was not able to sign papework and requested several times via email for resident representative to sign the contract indicating that it had been received. DM-H stated she made no other attempts other than email to have R3's contract signed by a representative for R3.	0 900		

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0 900	Continued From page 28 DM-H indicated that a blank copy of the licensee's assisted living contract had not been given to the Office of Ombudsmen for Long Term-Care. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=C	144.50 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	0 950		

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0 950	Continued From page 29 designated representative and a box the resident must initial if the resident declines to name a 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 offer the opportunity to identify a designated representative for two of three residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included, but were not limited to, dementia and left knee pain. R1's service plan dated August 27, 2021, indicated R1 received services which included medication administration and assistance with bathing, grooming and dressing. R1's Resident Information form dated August 27, 2021, indicated R1 had a supportive husband and family. R1's assisted living contract included a section to	0 950		

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0 950	Continued From page 30 identify or to decline a designated representative. The designated representatve section was blank and had not been completed. There was also no documentation showing R1 refused to indicate a representative. R3's diagnoses included, but were not limited to, dementia and hyponatremia. R3's undated, unsigned service plan indicated R3 received services which included medication administration and assistance with bathing, grooming, dressing and continence care. R3's assisted living contract included a section to identify or to decline a designated representative. The designated representatve section was blank and had not been completed. There was also no documentation showing R3 refused to indicate a representative On October 20, 2021, at approximately 10:55 a.m., the director of marketing (DM)-H indicated R1 and R3 and/or their representatives had not completed a designated representative form and also stated there was no documentation showing R1or R3 refused to indicate a representative. DM-H stated R3 was not able to sign papework and requested several times via email for resident representative to sign the required paperwork indicating resident request for a personal representative. DM-H stated she made no other attempts other than email to have R3's designated representative form completed and signed by resident representative. The licensee's Designated Representative policy was requested but not received.	0 950		

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0 950	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01540 SS=E	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 amount of dementia care training in the required time frame for two of two employees (registered nurse (RN)-A and unlicensed personnel (ULP)-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01540		

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01540	Continued From page 32	01540		

safety but had the potential to have harmed a resident's health or safety) 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 found to be pervasive).

The findings include:

The licensee has a current assisted living facility with dementia care (ALFDC) license effective August 1, 2021.

Registered nurse (RN)-A was hired September 14, 2021, and provided direct cares to residents of the facility.

Unlicensed personnel (ULP)-E had a hire date of July 26, 2011, and provided direct cares to residents of the facility.

RN-A's training and orientation records indicated 4 hours of dementia care training completed September 20, 2021.

On October 20, 2021, at 1:21 p.m., director of nursing (DON)-B verified RN-A completed 4 hours of dementia care training and stated RN-A had been working for "a month or two."

ULP-E's training and orientation records indicated ULP-E completed 5.75 hours of dementia care training within the past 18 months.

On October 20, 2021, at 12:55 p.m., RN-G verified ULP-E did not receive 8 hours of dementia care training on the required topics within the past 18 months.

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01540	Continued From page 33 The licensee's education policy, revised October, 2021, did not include current dementia education requirements. The licensee-provided dementia education grid indicated newly hired direct care staff would be required to have 8 hours of initial dementia care education within the first 80 work hours after hire. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
01620 SS=D	144G.70 Subd. 2 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	01620		

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01620	Continued From page 34 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) completed a timely comprehensive reassessment using the uniform assessment tool for two of three residents (R1, R3) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted August 27, 2021, and had diagnoses to include dementia and left knee pain. R1's record included documentation of a comprehensive nursing assessment completed September 1, 2021. On September 26, 2021, a wellness visit assessment is documented. No other physical assessments were documented in R1's record. R3's diagnoses included, but were not limited to, dementia and hyponatremia. R3's record included documentation of a comprehensive nursing assessment completed August 11, 2021. On August 27, 2021,	01620		

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01620	Continued From page 35 assessment-144G was completed. No other physical assessments were documented in R3's record. During an interview on October 20, 2021, at 10:28 a.m., director of nursing (DON)-B verified R1's assessment dated September 1, 2021, as the initial assessment. DON-B indicated R1 should have had a 14 day assessment completed. DON-B indicated that the wellness visit completed on September 27, 2021, was not the 14 day assessment but rather a weekly assessment that nursing staff complete. DON-B indicated the licensee's assessment-144G was also not considered a 14 day assessment. The licensee's Comprehensive Assessment Schedule dated October 12, 2018, indicated the director of health services (DHS) will ensure ongoing client monitoring and reassessment would be conducted 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (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	01650		

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01650	Continued From page 36 assessments of the resident; (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 service plans included all the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01650		

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01650	Continued From page 37 R1's service plan lacked the following: -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 -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. R2's service agreement, dated September 22, 2021, indicated R2 received services including medication administration and assistance with toileting, dressing, grooming. The service plan was not signed and lacked the following: -method of supervision and monitoring of staff. R2's service plan agreement indicated a name and phone number for an emergency contact but lacked any information in regards to who had the authority to sign for the resident in an emergency. On October 19, 2021, at 3:35 p.m., director of nursing (DON)-C verified the R2's service plan was not signed by the resident or the resident's representative. R3's service plan lacked the following: R3's service agreement was unsigned and undated and indicated services included medication administration and assistance with bathing, dressing, grooming, and continence care. R3's service plan agreement indicated a name and phone number for an emergency contact but lacked any information in regards who had the authority to sign for the resident in an emergency. R3's service plan agreement also lacked information indicated if resident had a	01650		

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01650	Continued From page 38 health care directive or not and when emergency services were not to be summoned. On October 20, 2021, at approximately 10:55 a.m., the director of marketing (DM)-H indicated R1 and R3 and/or their representatives had not provided a signature indicating they received a UDALSA listing all services provided under the facility's license, as well as the services not provided under the facility's license. DM-H stated that R1 had received a service agreement but had not provided a signature indicating acceptance of the services to be provided. DM-H stated R3 was not able to sign paperwork and requested several times via email for a resident representative to sign the service agreement indicating approval of services to be received. DM-H also stated she made no other attempts other than email to have R3's service agreement signed by a representative for R3. The licensee's Service Plan policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a	01730		

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01730	Continued From page 39 written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by:	01730		

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01730	Continued From page 40 Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for one of three residents (R1) with records reviewed. 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: R1's service plan, dated August 27, 2021, indicated R1 received medication administration two times per day and as needed. R1's service plan and record lacked evidence of: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; - identification of persons responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis; -procedure for staff notifying a registered nurse or appropriate licensed health professional when a problem arose with medication management services; -any resident specific requirements relating to documenting medication administration, verifications that all medications were administered as prescribed, and monitoring of medication use to prevent possible complications	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20551	A. BUILDING: _____ B. WING _____	10/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODBURY ESTATES	2825 WOODLANE DRIVE WOODBURY, MN 55125

(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
01730	Continued From page 41 or adverse reactions. R1's diagnoses included dementia and left knee pain. R1's medication and treatment administration record dated September 2021 indicated staff were administering medications two times per day to R1. During interview, director of nursing (DON)-B stated the results of R1's medication administration assessment would determine what medication services the resident would receive. DON-B also stated the service plan indicated R1 received medication administration two times per day and as needed based on the physician's orders. The licensee's Medication and Treatments policy dated August 2021, indicated all residents that were receiving services prior to initiating services, annually, and with a change in condition would have a medication and treatment management plan developed. The medication and treatment management plan would describe the medication, provide a description of storage for medications, document resident specific medication instructions, identify the person responsible for ordering supplies, and who and when the nurse would be notified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01730		
01910 SS=D	144G.71 Subd. 22 Disposition of medications	01910		

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	20551	A. BUILDING: _____ B. WING _____	10/22/2021

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01910	Continued From page 42 (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 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 provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R4) with record reviewed. 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	01910		

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01910	Continued From page 43 situation has occurred only occasionally). The findings include: R4 started services October 6, 2010, and was discharged on September 15, 2021, after receiving services for diagnoses including chronic kidney disease. R4's record lacked documentation of R4's disposition of medications to include: name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On October 19, 2021, at 1:43 p.m., director of nursing (DON)-C stated the disposition of medications was not documented for discharged resident R4. The licensee's Planned Discharge and Transfer Process or Resident Death policy, dated October 19, 2021, indicated the discharge process would include documentation of a medication disposition to include prescription and counts of medications released to responsible party or destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	01940		

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01940	Continued From page 44 services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R2) with records reviewed. 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	01940		

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01940	Continued From page 45 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 began receiving services on September 21, 2021. On October 20, 2021, at 12:01 p.m., licensed practical nurse (LPN)-F was observed providing wound care treatment to R2's right heel. R2's "Medication Sheet" documentation for October 2021 indicated gauze bandage roll, adaptic dressing, and sodium chloride (saline wound cleanser) was used for a wound on R2's right heel. R2's record included prescriber orders including a signed order dated October 6, 2021, to "clean wound to [R2's] R. [sic] heel with normal saline, apply adaptic, cover with gauze." R2's current Treatment Management Plan dated September 27, 2021, indicated R2 did not receive any treatment services, and did not indicate which staff would be responsible for treatment services provided. On October 20, 2021, at 11:37 a.m., director of nursing (DON)-C verified treatment orders for R2 dated October 6, 2021, and stated R2's treatment management plan should have been updated to reflect the ordered wound care treatment. The licensee's Medications & Treatments policy	01940		

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01940	Continued From page 46 reviewed August 2021 indicated the assisted living facility would "develop and maintain a current individualized Medication and Treatment Management Plan based on the tenant's assessment." The policy further indicated the medication and treatment record must be kept current and updated with any changes. No further information is available. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the proper documentation that a hazard vulnerability or safety risk assessment was performed on and around the property. This has the potential to affect all dementia care residents. This practice resulted in a level two violation (a	02040		

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02040	Continued From page 47 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 19, 2021, at approximately 11:15 a.m. while on a building tour with plant operations director (POD), surveyor observed the following items that would be good examples for the Hazard Vulnerability Assessment (HVA): -Large fish tank in memory care unit -Central pond -Locked exterior gate at memory care unit -Locked exterior gate at courtyard On October 19, 2021, at approximately 11:45 a.m. while reviewing records, the licensee provided no evidence of a completed hazard vulnerability assessment. On October 19, 2021, at approximately 12:00 p.m. the POD confirmed the facility had not yet fully developed the required hazard vulnerability assessment. Global issues such as fire, gas leak, epidemic, and shooter had been identified. The POD indicated local hazards that are site, building, and population specific had not been developed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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02240	Continued From page 48	02240		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate	02240		

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02240	Continued From page 49 because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current "Minnesota Bill of Rights for Assisted Living Residents" was provided to the resident and a written acknowledgement received for one of three residents (R3) with records reviewed. 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: R3 began receiving assisted living services August 4, 2021. R3's record lacked evidence of a current bill or rights, a written acknowledgement, and the process for filing a complaint. On October 20, 2021, at approximately 10:55 a.m., the director of marketing (DM)-H indicated R3 and/or their representatives had not provided a signature indicating R3 received a Minnesota Home Care Bill of Rights. DM-H stated R3 was not able to sign paperwork	02240		

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	20551	A. BUILDING: _____ B. WING _____	10/22/2021

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02240	Continued From page 50 and requested several times via email for resident representative to sign the checklist indicating that it had been received. DM-H also stated she made no other attempts other than email to have R3's representative sign a checklist indicating they did receive a Minnesota Home Care Bill of Rights. The licensee's Minnesota Bill of Rights Policy was requested but not received. Licensee made available a copy of the Minnesota Bill of Rights Notifications Policy, dated May 16, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all sixty-one (61) residents	03090		

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03090	Continued From page 51 residing in the Assisted Living facility, staff, and any visitors of the licensee. 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 finding include: On October 19, 2021, at approximately 9:50 a.m., observation was made of the facility's common areas and noted the posted signage lacked the required verbiage regarding electronic monitoring. On October 20, 2021, during the 1:50 p.m. exit conference, licensed assisted living director (LALD)-D verified there was no signage posted indicating electronic monitoring. The licensee's Electronic Monitoring policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *10/19/21*
Time: 11:25:51
Report: 1004211237

Food and Beverage Establishment Inspection Report

Location:
Woodbury Estates
2825 Woodlane Drive
Woodbury, MN55125
Washington County, 82

Establishment Info:
ID #: 0039086
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6515012100
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER BLADE WAS FOUND WITH AN ACCUMULATION OF FOOD RESIDUES AND METAL SHAVINGS. ENSURE BLADE IS THOROUGHLY CLEANED AFTER USE AND MAINTAINED.

Comply By: 10/19/21

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET WIPING CLOTH BUCKET ON THE COOKLINE WAS FOUND TO HAVE A QUATERNARY AMMONIUM CONCENTRATION OF 0PPM. ENSURE A CONCENTRATION OF 150-400PPM IS MAINTAINED TO PREVENT BACTERIAL GROWTH. *BUCKET WAS REFILLED DURING INSPECTION- CORRECTED ON SITE.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 0PPM at Degrees Fahrenheit
Location: WET WIPING CLOTH BUCKET (COOKLINE)
Violation Issued: Yes

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

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 40 Degrees Fahrenheit - Location: TRAULSEN COOLER
Violation Issued: No

Process/Item: GROUND BEEF
Temperature: 180 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: HARD BOILED EGG
Temperature: 40 Degrees Fahrenheit - Location: TURBO AIR COOLER
Violation Issued: No

Process/Item: HAM
Temperature: 39 Degrees Fahrenheit - Location: TURBO AIR COOLER
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION SURVEY.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-PREVENTING BAREHAND CONTACT
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DATE MARKING PROCEDURES
-FOOD PREPARATION (PREPARED AND SERVED THE SAME DAY)
-COOLING PROCEDURES (FROM AMBIENT TEMPERATURES)
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW OR UNDERCOOKED ANIMAL PROTEINS, NO UNPASTEURIZED MILK, JUICE, ETC)
-RECEIVING DELIVERIES PROCEDURES
-PEST CONTROL
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES (NOT DONE BY KITCHEN STAFF)
-ALL VIOLATIONS ON THIS REPORT

*ALL VIOLATIONS ON THIS REPORT WERE DISCUSSED WITH THE FOOD SERVICE DIRECTOR.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455

Food and Beverage Establishment Inspection Report

Establishment Info: FACILITY IS RATED FOR 74 RESIDENTS. KITCHEN IN WOODBURY ESTATES OPERATES IN CONJUNCTION WITH ADDITIONAL KITCHENS THROUGH DIFFERENT FACILITIES ON THE CAMPUS. EACH FACILITY HOLDS THEIR OWN LICENSE.

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 1004211237 of 10/19/21.

Certified Food Protection Manager: NATHAN B. JOHNSON

Certification Number: FM103749 Expires: 08/10/23

Signed: _____

NATHAN JOHNSON
FOOD SERVICE DIRECTOR

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us

Report #: 1004211237

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1	**Date**	10/19/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:25:51
Legal Authority MN Rules Chapter 4626		**Time Out**	

Woodbury Estates	**Address** 2825 Woodlane Drive	**City/State** Woodbury, MN	**Zip Code** 55125	**Telephone** 6515012100
License/Permit # 0039086	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	IN	(OUT)	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	(N/A)	N/O	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	(IN)	OUT	N/A	N/O	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	(IN)	OUT	N/A		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

				COS	R
Safe Food and Water					
30	(IN)	OUT	N/A		
31			Water & ice obtained from an approved source		
32	IN	OUT	(N/A)		
Food Temperature Control					
33			Proper cooling methods used; adequate equipment for temperature control		
34	IN	OUT	N/A (N/O)		
35	(IN)	OUT	N/A N/O		
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	X		Wiping cloths: properly used & stored	X	
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:** 10/19/21

Inspector (Signature) Molly Dougherty