October 18, 2023

Licensee
Covenant Living of Golden Valley Assisted Living
5800 St Croix Avenue North
Crystal, MN 55422

RE: Project Number(s) SL21715015

Dear Licensee:

On October 13, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 30, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Electronically Delivered

September 21, 2023

Licensee
Covenant Living of Golden Valley Assisted Living
5800 St Croix Avenue North
Crystal, MN 55422

RE: Project Number(s) SL21715015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH 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 (b), 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, the following fines are assessed pursuant to this survey:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

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

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

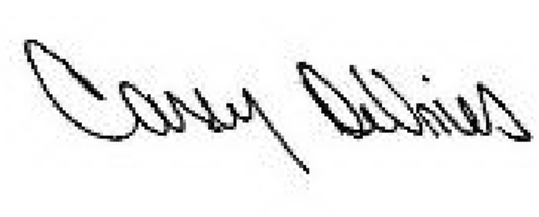
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21715	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLGV ASSISTED LIVING	5800 ST CROIX AVENUE NORTH CRYSTAL, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21715015-0 On August 28 through August 30, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 217 residents, 27 of whom received services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 29, 2023, issued for SL21715015-0, tag identification 2310. On August 29, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 130 SS=C	144G.12, Subd. 1 Application for Licensure	0 130		

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0 130	Continued From page 1 Each application for an assisted living facility license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership	0 130		

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0 130	Continued From page 2 interest in the licensee of five percent or greater and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal	0 130		

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0 130	Continued From page 3 Regulations, title 42, section 1001.101 or 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted,	0 130		

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0 130	Continued From page 4 conditioned, refused, not renewed, or revoked under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to meet the requirements of licensure for the assisted living license they possessed. This had the potential to affect all 217 residents, staff, and visitors. 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 the potential to affect a large portion or all the residents). The findings include: The licensee's assisted living (AL) license effective January 1, 2023, indicated a capacity of 50 assisted living residents. The licensee's Application for Assisted Living license indicated 50 assisted living residents and was signed by licensed assisted living director/registered nurse (LALD/RN)-D on October 28, 2022. On August 28 through 30, 2023, the surveyor observed the facility layout and entrance. The facility had one main entrance and open lobby with no barriers separating what the licensee	0 130		

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0 130	Continued From page 5 considered to be their AL portion of the building and thier independent living (IL) portion of the building. On August 28, 2023, at 10:34 a.m., during the entrance conference, LALD/RN-D stated they had 27 AL residents receiving services. LALD/RN-D stated they had IL residents also, but asserted they were not associated with the AL license, and they were unsure of the IL resident census. LALD/RN-D provided an AL resident roster which included 27 residents. On August 28, 2023, at 11:25 a.m., LALD/RN-D stated the IL residents were separate from the AL residents as they were housed in separate halves of the building. They stated they were not accounting for IL residents under their AL license census. On August 29, 2023, at 7:35 a.m., nursing manager RN-A, stated the IL residents were all in one side of the building while the AL residents were on the other side of the building, so they didn't have to account for the IL residents as a part of their AL license census. RN-A stated IL and AL residents were in the same building with the same address which shared an entrance and lobby. On August 29, 2023, at 9:55 a.m., LALD/RN-D provided their IL resident roster which included 190 residents. The combined census of 217 total residents exceeded the licensee's AL license capacity by 167 residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 130		

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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: (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 adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents at the 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated August 29, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 7 (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 develop and implement an individual abuse prevention plan for each vulnerable adult residing in the assisted living facility including 190 housing only 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) 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: The licensee's Current Resident Roster indicated there were 27 assisted living (AL) residents living in the facility. The licensee's Resident Directory indicated there were 190 independent living (IL) residents living in the facility.	0 630		

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0 630	Continued From page 8 On August 28, 2023, at 10:34 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-D stated they had 27 AL residents receiving services. LALD/RN-D stated they had IL (housing only) residents, but they were not associated with their AL license, they were unsure of their IL census. On August 28, 2023, at 11:25 a.m., LALD/RN-D stated they did not have to account for the IL residents as they were not a part of their AL license, and they were not completing IAPP's for the 190 IL residents. On August 29, 2023, at 7:35 a.m., nursing manager RN-A stated they were unsure if IAPP assessments were completed for the IL residents. On August 29, 2023, at 9:55 a.m., LALD/RN-D and RN-A stated they were not completing IAPP assessments for IL residents. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	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	0 650		

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0 650	Continued From page 9 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained required documentation of completed orientations and trainings for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: RN-A RN-A was hired by the licensee's ownership umbrella under the former licensure on October 7, 1985. RN-A began providing assisted living oversite to unlicensed personnel and direct care	0 650		

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0 650	Continued From page 10 to residents on August 1, 2021, following the implementation of the assisted living licensure. RN-A's employee record included a Relias (online training platform) transcript. RN-A's employee record lacked documentation of orientation and training for the following: -overview of assisted living statutes; -assisted living bill of rights; and -handling of resident complaints, reporting of complaints, and where to report. ULP-B ULP-B was hired by the licensee's ownership umbrella under the former licensure on March 28, 2011, and began providing assisted living services on August 1, 2021, following the implementation of the assisted living licensure, and was observed providing direct cares to residents on August 29, 2023. ULP-B's employee record included a Relias transcript. ULP-B's employee record lacked orientation and training for the following: -assisted living bill of rights; -handling of resident complaints, reporting of complaints, and where to report; and -principles of person-centered planning/service delivery. ULP-B's employee record lacked the following competency and supervision: -medication administration and unplanned times away; and -30-day RN supervision. On August 28, 2023, at 10:34 a.m., during the	0 650		

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0 650	Continued From page 11 entrance conference, licensed assisted living director/registered nurse (LALD/RN)-D stated they were aware of the required contents of employee records. On August 29, 2023, at 7:48 a.m., ULP-B stated they had been trained in medication administration and unplanned times away for residents with medications. ULP-B stated they had been observed by an RN completing both tasks. They stated they did receive the above orientations and training. On August 30, 2023, at 8:53 a.m., RN-A stated ULP-B had received training in medication administration and unplanned times away for residents with medications but lacked documentation. RN-A stated they completed a RN 30-day supervision for ULP-B but lacked documentation. RN-A stated they completed their own required trainings but lacked documentation. On August 30, 2023, at 10:30 a.m., LALD/RN-D stated they had somehow, gotten behind on orientations and trainings with their staff for multiple staff member or did not have documentation they were completed. The licensee's Staff Training policy, undated, indicated, "Direct care staff for residents will receive initial orientation and ongoing inservice training based on state regulations and the needs of the residents being served in the community." It further indicated, "All training will be documented. Copies of documentation will be retained in the employee record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 650		

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0 650	Continued From page 12 (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: Based on observation, interview, and record review, the licensee failed to ensure tuberculosis (TB) testing was completed at the time of hire, or within 90-days prior to the date of hire, for one of two employees (registered nurse (RN)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	0 660		

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0 660	Continued From page 13 The findings include: The Facility TB Risk Assessment dated June 15, 2022, identified the facility was at a low risk for TB transmission. Registered nurse (RN)-A was hired on October 7, 1985, under the former licensure, to provide oversite to unlicensed personnel and direct care to residents. They were observed interacting with staff and residents on August 28-30, 2023. RN-A's employee record contained an Annual TB Screening Tool for Healthcare Workers dated June 18, 2018, which included baseline symptom screening but lacked TB testing by either a TB blood test or a two-step TST Mantoux. On August 30, 2023, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they would look further for RN-A's TB testing and screening documents. On August 30, 2023, at 11:36 a.m., RN-A provided an Annual TB Screening Tool for Healthcare Workers for themself but stated they did not have TB testing results. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. The licensee's TB Prevention and Control policy dated February 2015, and referenced Home Care Law - MN Statutes 144A.4799 and CDC 2005 TB Guidelines, indicated the licensee would maintain all reports of TB screening in the personnel files	0 660		

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0 660	Continued From page 14 of home care employees and: "TB screening for Home Care Staff At time of hire and prior to any contact with residents, all home care employees and all volunteers will be screened for Tuberculosis. a. Prior to contact with residents, the RN will review TB symptoms with each new home care employee and with any volunteers having direct resident contact. b. Prior to contact with residents, each staff person will be screened for TB. A two-step skin test will be administered unless the person's past medical history indicates that a TB skin test is contraindicated. Individuals who have been vaccinated with Bacillus Calmette-Guerin (BCG) vaccine are not exempt from tuberculin skin testing. Pregnant women are not exempt from tuberculin skin testing unless they have filed the exemption form for TB skin testing of a pregnant health care worker. The RN will follow the MOH guidance regarding how to screen employees with a previous or current positive TST or TB blood test or with a documented history of previous treatment for latent TB infection (L TBI) or active TB disease. For any questions the RN will contact the MDH TB staff at 651-201-5414 or 1-877-676-5414." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the	0 950		

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0 950	Continued From page 15 contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a 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 include verbatim language, separate from the resident contract, giving residents the right to identify a designated representative for three of three residents (R1, R2, R3). 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	0 950		

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0 950	Continued From page 16 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 28, 2023, the licensee provided a blank copy of their Assisted Living Agreement which lacked a revision date. R1's record included an Assisted Living Agreement signed on August 14, 2023. R2's record included an Assisted Living Agreement signed on January 6, 2023. R3's record included an Assisted Living Agreement signed on September 22, 2021. The licensee's blank Assisted Living Agreement along with R1, R2 and R3's Assisted Living Agreements included the required verbatim language and gave residents the opportunity to identify a designated representative, however the verbatim language was not provided on a document separate from the contract. On August 30, 2023, at 12:10 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated the verbatim language was only in the contract and could not be found separate from the contract. They stated they were unaware of the statute requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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0 970	Continued From page 17	0 970		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for two of three residents (R2, R3). 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 the potential to affect a large portion or all the residents). The findings include: On August 28, 2023, the licensee provided a blank copy of their Assisted Living Agreement which lacked a revision date. R2's record included an Assisted Living Agreement signed on January 6, 2023. R3's record included an Assisted Living	0 970		

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0 970	Continued From page 18 Agreement signed on September 22, 2021. The licensee's blank Assisted Living Agreement along with R2 and R3's signed Assisted Living Agreement's included the following waivers of liability: "The Corporation shall not be responsible for the loss of or any damage to any furniture, furnishings or other property belonging to Resident resulting from theft, water, fire or any other cause. The Corporation's insurance does not cover Resident's property. It is Resident's responsibility to obtain Insurance for Resident's property. Resident and Corporation mutually waive their rights of subrogation against each other in the event of fire damage to property owned by the Corporation or by Resident." On August 30, 2023, at 12:10 p.m., licensed assisted living director/registered nurse (LALD/RN)-D stated they updated their Assisted Living Agreement but had not gone through resident records to add an addendum to old ones which contained waivers of liability. LALD/RN-D stated they had a new contract which had the liability waiver removed from it and had provided a blank copy of the old one by mistake. LALD/RN-D stated R1's Assisted Living Agreement used the most current version and was why R1's Assisted Living Agreement did not have the waiver of liability in it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors	01460		

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01460	Continued From page 19 All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living statutes for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired by the licensee's ownership umbrella under the former licensure on March 28, 2011, and began providing assisted living services on August 1, 2021, following the implementation of the assisted living licensure, and was observed providing direct cares to residents on August 29, 2023. ULP-B's employee record lacked orientation to the current assisted living statutes which went	01460		

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01460	Continued From page 20 into effect on August 1, 2021. On August 28, 2023, at 10:34 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-D stated they were aware of the required contents of employee records. On August 29, 2023, at 7:48 a.m., ULP-B stated they had not received orientation to the new assisted living statutes. The licensee's Staff Training policy, undated, lacked assisted living statute training as a topic of orientation or training. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective	01500		

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01500	Continued From page 21 gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01500		

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01500	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment in all required training topics for one of two direct care employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B was hired by the licensee's ownership umbrella under the former licensure on March 28, 2011, and began providing assisted living services on August 1, 2021, following the implementation of the assisted living licensure, and was observed providing direct cares to residents on August 29, 2023. ULP-B's employee record included a Relias transcript which lacked annual training for the following: -reporting maltreatment of vulnerable adults or minors; -effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with resident's who have dementia, Alzheimer's disease or related disorders; -review of provider's policies and procedures; and	01500		

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01500	Continued From page 23 -principles of person-centered planning/service delivery. On August 28, 2023, at 10:34 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-D stated they were aware of the required contents of employee records. On August 30, 2023, at 10:30 a.m., LALD/RN-D stated somehow, they had gotten behind with orientation and annual trainings and was an issue with multiple staff members. On August 30, 2023, at 11:36 a.m., registered nurse (RN)-A stated ULP-B was behind on their annual trainings which included the required topics listed above. The licensee provided page two of three of an untitled document which indicated, "Direct-care employees must have completed at least eight hours of initial training on the above topics within 80 working hours of the employment start date and must have at least two hours of training on the above topics related to dementia for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at	01530		

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01530	Continued From page 24 least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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 observation, interview, and record review, the licensee failed to provide employees with two hours of required annual dementia care training for one of two direct care employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21715	A. BUILDING: _____ B. WING _____	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLGV ASSISTED LIVING	5800 ST CROIX AVENUE NORTH CRYSTAL, MN 55422

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01530	Continued From page 25 The findings include: ULP-B was hired by the licensee's ownership umbrella under the former licensure on March 28, 2011, and began providing assisted living services on August 1, 2021, following the implementation of the assisted living licensure, and was observed providing direct cares to residents on August 29, 2023. ULP-B's employee record included a Relias (online training platform) transcript with the most recent dementia care training having been completed on July 2, 2022. ULP-B's employee record had zero hours of annual dementia care training completed in the past year. On August 28, 2023, at 10:34 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-D stated they were aware of the required contents of employee records. On August 30, 2023, at 10:30 a.m., LALD/RN-D stated somehow, they had gotten behind with orientation and annual trainings and was an issue with multiple staff members. On August 30, 2023, at 11:36 a.m., registered nurse (RN)-A stated ULP-B was behind on their annual trainings which included their annual dementia care training. The licensee provided page two of three of an untitled document which indicated, "Direct-care employees must have completed at least eight hours of initial training on the above topics within	01530		

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01530	Continued From page 26 80 working hours of the employment start date and must have at least two hours of training on the above topics related to dementia for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 27 by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a 14-day assessment no more than 14 calendar days after initiation of services for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on September 22, 2021. R3's Service Plan dated September 22, 2022, indicated R3 received services for bathing, bed making, laundry, mobility and remove trash. R3's record included an admission RN Assisted Living Assessment completed on September 22, 2021, but lacked a 14-day RN assessment required to be completed by October 6, 2022. On August 28, 2023, at 10:34 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-D stated their RN assessments were completed at preadmission/admission, then within five-days after admission, then within 14 days after admission, then every 90 days and annually. On August 30, 2023, at 12:10 p.m., RN-A stated they could not locate a five-day or 14-day RN	01620		

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01620	Continued From page 28 assessment for R3. The surveyor stated a five-day RN assessment was not required per statute. RN-A and LALD/RN-D stated they should stop doing the five-day assessments to simplify their assessment schedule. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated September 2014, indicated it referenced (MN Statutes 144A.4791 subd.8; 144A.4792 subd. 2,3,4) which was a home care statute and was not relevant to the licensee's assisted living license. It indicated, "An RN will complete a nursing assessment of each prospective resident either within five days before moving into the assisted living facility, or at least before any delegated tasks are provided. The assessment will be the basis for the service plan that the RN will recommend to the prospective resident and the basis for the care plan that staff will follow when implementing the resident's services. The RN will reassess and monitor resident services in the resident's apartment no more than 14 days after initiation of services. The RN will also reassess the resident and update the service plan based on the resident's needs and at a frequency not to exceed 90 days from the last date of the assessment. The 90 day assessments may be done in the resident's apartment or remotely using telecommunications. The RN will review the nursing assessment and service plan and, if necessary, will update the assessment and service plan whenever the resident has experienced a change of condition." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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02310	Continued From page 29	02310		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R1) who utilized a consumer bed rail. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This practice resulted in an immediate correction order on August 29, 2023, at approximately 12:35 p.m. The findings include: R1 was admitted to the licensee on August 10, 2023. R1's Service Plan dated August 9, 2023, indicated R1 received services for dressing, incontinence care, laundry, ambulation assistance, showering, and bed making.	02310	On August 29, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three, isolated scope.	

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02310	Continued From page 30 R1's resident record included an Adaptive Bed Device Assessment form dated August 15, 2023, which indicated R1 was independent with transfers, independent with bed mobility, type of bed device, able to recognize potential safety concerns, medical conditions which included physical and mental status, and reasons why the bed rail device was appropriate and beneficial. R1's resident record included an Assisted Living Assessment 5-day assessment dated August 15, 2023, and indicated R1 was independent with transfers to and from the bed, chair, laying, sitting, standing and could tolerate distances and sustained activity. The assessment lacked information and acknowledgement of bed rail use. R1's resident record included an Assisted Living Assessment 14-day assessment dated August 29, 2023, (during survey) and indicated R1 was independent with transfers to and from the bed, chair, laying, sitting, standing and could tolerate distances and sustained activity. It indicated R1 had an assist handle on the bed and had demonstrated safe use. On August 28, 2023, at 10:34 a.m., during the entrance conference, licensed assisted living director/registered nurse (LALD/RN)-D stated they did complete bed rail assessments and used the Occupational Safety and Health Administration (OSHA) bed rail guidance. On August 28, 2023, at 12:22 p.m., the surveyor observed a black bed rail with 5 horizontal bars attached to the right side of the head of R1's bed. The bed rail was approximately 1/3 of the length of the twin bed. The right side of the bed and the head of the bed were pushed up against a wall in	02310		

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02310	Continued From page 31 the corner of the room. The surveyor shook and pulled on the bed rail which was reasonably sturdy. R1 stated the bed rail was provided by himself and his friend (F)-G. F-G stated they had installed it themselves when R1 admitted to the licensee but were unsure of the exact date. R1 stated the facility knew he had it as they were in his room providing cares on a regular basis. R1 stated he really liked having the bed rail as it can be very helpful at times to get themself out of bed. On August 29, 2023, at 9:55 a.m., registered nurse (RN)-A stated R1's bed rail was installed by F-G. RN-A stated they assessed if the bed rail was installed properly when it was discovered on August 15, 2023, by wiggling and pulling on it. RN-A stated it seemed sturdy, and they also completed Adaptive Bed Device Assessment with risk versus benefits notification to the resident. RN-A stated they did not have a copy of the manufacturer instructions and had not referred to the manufacturer instructions for proper installation. On August 29, 2023, at 10:55 a.m., RN-A stated they found the box the bed rail came in and were able to look up the manufacturer instructions online and would use them to check for proper installation. On August 29, 2023, at 12:04 p.m., RN-A stated they had not checked with the Consumer Product Safety Commission (CSPC) to see if R1's bed rail had been recalled. LALD/RN-D checked the CSPC website for any recalls in the surveyor's presence, there was no recall. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised	02310		

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02310	Continued From page 32 April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines;	02310		

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02310	Continued From page 33 - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". In addition, the MDH website indicated, "licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information." The licensee's Assessing the Safety of Side Rails policy, undated and without licensee specific information, indicated: "1. The RN will train staff to be alert for any side rail or equipment that resembles a side rail that a client [resident] may be using or considering using and to notify the RN immediately about the side rail or equipment. 2. When notified that a client has a side rail, the RN will assess and evaluate what the client's needs are and assess to determine if the client can safely utilize the side rail/equipment and determine whether the side rail/equipment meets the FDA standards for side rails. 3. The RN will provide for any client who has a side rail or is considering obtaining one and, if appropriate, the RN will educate the client's representative and/or the client's family regarding side rail safety and risks including potential death due to falls, entrapment and asphyxiation. If the RN determines that the client is not able to safely use a side rail, or that the client's side rail does not meet the FDA or most current safety guidelines, the RN will recommend that the side rail should be removed and will document this recommendation, will document to whom the education was directed and will document the person who was given the recommendation to remove the side rail.	02310		

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02310	Continued From page 34 4. If the RN determines that the side rails are not a safe device for the client, the RN will provide options and alternatives for reducing fall or positioning self to the client, the client's representative and/or the client's family. The RN will document these recommended options and the response from the client, client's family and client's representative to the RN's recommendations." No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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

Type: Full
Date: *08/29/23*
Time: 11:04:12
Report: 8058231180

Food and Beverage Establishment Inspection Report

Location:
Clgv Assisted Living
5800 St Croix Avenue North
Golden Valley, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0038039
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637321434
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

ITEM IN COUNTER TOP PREP UNIT (BISTRO KITCHEN) NOT AT OR BELOW 41 DF

Comply By: 08/29/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

REPAIR/REPLACE COUNTER TOP PREP UNIT IN BISTRO KITCHEN

Comply By: 09/29/23

8-500A Embargo/Condemnation

8-501.03MN

MN Rule 4626.1810 The following items are condemned and shall be removed from the establishment immediately:

REMOVED ALL ITEMS FROM COUNTER TOP PREP UNIT STORED OVERNIGHT (CHIK, SALAD, TUNA SALAD, EGG SALAD, MAYO)

Corrected on Site

Surface and Equipment Sanitizers

Acid: = 700 MLL at --- Degrees Fahrenheit
Location: SANI SINK
Violation Issued: No

Hot Water: = --- at 163 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: HB EGG
Temperature: 39 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: STRAWBERRY
Temperature: 40 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: LIQUID EGG
Temperature: 41 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: HAM
Temperature: 41 Degrees Fahrenheit - Location: COLD DRAWER
Violation Issued: No

Process/Item: CHICK SALAD
Temperature: 47 Degrees Fahrenheit - Location: COUNTER TOP COOLING UNIT
Violation Issued: Yes

Process/Item: EGG SALAD
Temperature: 46 Degrees Fahrenheit - Location: COUNTER TOP COOLING UNIT
Violation Issued: Yes

Process/Item: RICE
Temperature: 40 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: COOKED CHICKEN
Temperature: 41 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: POTATO
Temperature: 140 Degrees Fahrenheit - Location: HOT HOLD
Violation Issued: No

Process/Item: CHICKEN
Temperature: 40 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

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

HRD INSPECTION

HRD SURVEYOR: JOEY KEEN

Type: Full
Date: *08/29/23*
Time: 11:04:12
Report: 8058231180
Clgv Assisted Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058231180 of 08/29/23.

Certified Food Protection Manager: NICHOLAS LINDQUIST

Certification Number: 64519 Expires: 01/14/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us