Electronically Delivered

August 3, 2023

Licensee
Folkestone North
100 Promenade Avenue
Wayzata, MN 55391

RE: Project Number(s) SL29889015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

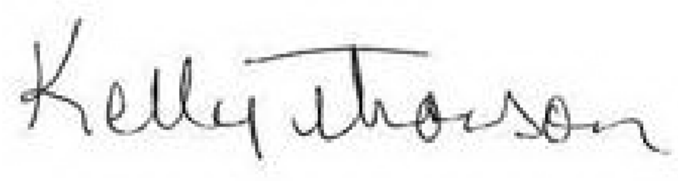
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29889	A. BUILDING: _____ B. WING _____	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE NORTH	100 PROMENADE AVENUE WAYZATA, MN 55391

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29889015 On July 10, 2023, through July 13, 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 75 active residents, all of whom received services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.? This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's 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 potential to affect a large portion or all of the residents). The findings include: LALD-B had a license effective through October 31, 2023. However, LALD-B's license lacked an organization listed as the Director of Record with BELTSS. On July 10, 2023, at 10:20 a.m., the surveyor observed the BELTSS website with LALD-B, and LALD-B stated the Director of Record was not listed with BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		

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0 480	Continued From page 2	0 480		
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 ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 12, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 3 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for one of three employees (unlicensed personnel/ULP-E) observed while providing cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 12, 2023, at 8:03 a.m., the surveyor observed ULP-E provide morning cares to one resident (R4) in her apartment. With gloved hands, ULP-E removed the used incontinent brief from R4, touched the sling on the standing lift, touched the resident's clothing on her body,	0 510		

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0 510	Continued From page 4 touched the remote while lowering the lift, and touched the bathroom door, and touched the remote on the bed. ULP-E then removed the gloves and washed her hands in the kitchen sink. At 8:35 a.m., ULP-E donned clean gloves and assisted R4 in the bathroom. ULP-E raised R4 up in the standing lift, performed perineal cares in the back, disposed of the wipe and took a clean wipe. ULP-E performed perineal cares in the front with the new wipe. ULP-E took the Lidocaine cream and squeezed some out on her gloved hand, and rubbed it on R4's back as directed. ULP-E pulled up the new incontinent brief, pulled up R4's pants, adjusted her shirt, lowered the lift with the remote and her gloved hand, touched the lift, the sling, and pushed R4 in the wheelchair to the sink so R4 could brush her teeth. ULP-E removed gloves and washed her hands in the bathroom sink. On July 12, 2023, at 9:05 a.m., ULP-E stated she was trained and should have done hand hygiene after removing her gloves, and after performing a dirty task. ULP-E also stated she was trained to do perineal cares from the front to the back. On July 12, 2023, at 9:10 a.m., registered nurse (RN)-D stated gloves should be changed after removing the incontinent brief, after performing perineal cares, and after removing gloves. RN-D also stated hand hygiene should be done before any medication administration. The licensee's Infection Control policy dated 2020 noted hand hygiene should be performed after contact with blood or body fluids, after contact with visibly contaminated services, and before donning and doffing personal protective equipment.	0 510		

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0 510	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (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 was developed to include the required content for two of five residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	0 630		

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0 630	Continued From page 6 The findings include: R4 R4's diagnoses included dementia. R4's Individual Abuse Prevention Plan dated June 21, 2023, noted the resident was at risk to be abused. However, under the comments / plan of action was noted "A.L. [assisted living] resident," but lacked statements of specific measures to be taken to minimize the risk of abuse. R4's Service Plan dated June 10, 2023, noted services including medication management, and assistance with showers and transfers. R5 R5's diagnoses included a right hip fracture. R5's Individual Abuse Prevention Plan dated May 28, 2023, noted the resident was at risk to be abused. However, under the comments / plan of action was noted "AL [assisted living] resident.", but lacked statements of specific measures to be taken to minimize the risk of abuse. R5's Service Plan dated May 28, 2023, noted services including medication management, oxygen management, and blood sugar monitoring. On July 13, 2023, at 11:40 a.m., clinical nurse supervisor (CNS)-A stated staff would look for concerns and report per policy. However, CNS-A stated no specific actions or measures were noted for either resident. The licensee's Nursing Assessment policy dated revised May 3, 2022, noted an assessment of the resident's areas of vulnerability and susceptibility	0 630		

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0 630	Continued From page 7 to maltreatment and whether the resident poses a risk to other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the	0 650		

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0 650	Continued From page 8 employee records contained the required content for two of three employees (unlicensed personnel/ULP-E and ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: ULP-E ULP-E began employement on December 17, 2021, to provdie direct care to residents. On July 12, 2023, at 8:03 a.m., the surveyor observed ULP-E assist R4 with morning cares. ULP-E's employee record lacked documentation of an annual performance review. On July 13, 2023, at 12:30 p.m., human resources (HR)-F stated an annual performance had not been completed. ULP-C ULP- C began employment on September 9, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On July 11, 2023, at 8:03 a.m., the surveyor observed ULP-C assist R1 with morning medications.	0 650		

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0 650	Continued From page 9 ULP-C's employee record lacked documentation of an annual performance review. On July 11, 2023, at 2:02 p.m., human resources (HR)-F stated an annual performance is not current in the employee file. The licensee's Employee Handbook, page 10 provided, undated, noted it was the licensee policy to evaluate the performance annually on or about the anniversary date of the hire date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	01290		

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01290	Continued From page 10 Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for one of three employees (unlicensed personnel/ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E began employement on December 17,2021 to provide direct care and assisted living services. On July 12, 2023, at 8:03 a.m., the surveyor observed ULP-E assist R4 with morning cares. ULP-E's employee record contained a Background Study Clearance dated December 17, 2021. However, the document was not affiliated with the facility's license. On July 13, 2023, at 12:30 p.m., licensed assisted living director (LALD)-B reviewed the clearance, and stated it was not affiliated with the facility's license. The licensee's Background Check policy dated April 13, 2018, noted all employees seeking to transfer or add an alternate job or site for which a background check would be required, would be subject to the required criminal background	01290		

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01290	Continued From page 11 check. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of two unlicensed personnel (ULP)-E. 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	01380		

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01380	Continued From page 12 resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E began employement on December 17,2021 to provide direct care and assisted living services. On July 12, 2023, at 8:03 a.m., the surveyor observed ULP-E assist resident (R4) with morning cares. ULP-E's employee record lacked documented evidence of the following required training: - recognizing physical, emotional, cognitive, and developmental needs of the resident. On July 13, 2023, at 12:30 p.m., human resources (HR)-F stated the employee record lacked the above required training. A policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's	01470		

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	29889	A. BUILDING: _____ B. WING _____	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE NORTH	100 PROMENADE AVENUE WAYZATA, MN 55391

(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
01470	Continued From page 13 policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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	01470		

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01470	Continued From page 14 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of three employees (unlicensed personnel/ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E began employment on December 17, 2021 to provide direct care and assisted living services. On July 12, 2023, at 8:03 a.m., the surveyor observed ULP-E assist R4 with morning cares.	01470		

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01470	Continued From page 15 ULP-E's employee record lacked documented evidence of the following: - an overview of the Assisted Living statutes. On July 13, 2023, at 12:30 p.m., human services (HR)-F stated ULP-E had not received the required training to include an overview of the Assisted Living statutes. A policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	01500		

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01500	Continued From page 16 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12	01500		

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01500	Continued From page 17 months of employment for one of three employees (unlicensed personnel/ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E began employment on December 17, 2021 to provide direct care and assisted living services. On July 12, 2023, at 8:03 a.m., the surveyor observed ULP-E assist R4 with morning cares. ULP-E's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;	01500		

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01500	Continued From page 18 - 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 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 13, 2023, at 12:30 p.m., human resources (HR)-F stated ULP-E had not completed the required annual training. A policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions	01700		

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01700	Continued From page 19 needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment with the required content for two of five residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: During the entrance conference on July 10, 2023, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. R4 and R5's records lacked documented evidence the RN conducted a medication assessment to include: - identification and review of all medications the	01700		

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01700	Continued From page 20 resident was known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address those issues. R4 R4's diagnoses included dementia. On July 12, 2023, at 8:24 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R4 in her apartment. R4's Service Plan dated June 10, 2023, noted services including medication management, and assistance with showers and transfers. R4's Assessment by Date dated June 21, 2023, noted R4 required assistance taking medications. However, it lacked the above required content. R4's July 2023 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials through July 11, 2023, to indicate the medications had been given. R5 R5's diagnoses included a right hip fracture. On July 12, 2024, at 8:53 a.m., the surveyor observed RN-D administer insulin to R5 in her apartment. R5's Service Plan dated May 28, 2023, noted services including medication management, oxygen management, and blood sugar monitoring.	01700		

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01700	Continued From page 21 R5's Assessment by Date dated May 28, 2023, noted R5 required assistance taking medications. However, it lacked the above required content. R5's July 2023 Med (Medication) Admin (Administration) Summary listed medications as prescribed, times to administer, and staff initials through July 11, 2023, to indicate the medications had been given. On July 13, 2023, at 11:40 a.m., clinical nurse supervisor (CNS)-A stated she was not aware if the required content had been reviewed or documented for the medication assessment for R4 and R5. The licensee's AL Medication Management Policy dated updated June 6, 2023, noted the registered nurse would conduct a face-to-face assessment of the resident's need for medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a	02410		

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02410	Continued From page 22 lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of four residents (R4) was treated with dignity and respect when unlicensed personnel (ULP)-E provided morning cares to R4 with the bedroom blinds open. 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: R4's diagnoses included dementia. R4's Service Plan dated June 10, 2023, noted services including medication management,	02410		

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02410	Continued From page 23 assistance with showers and transfers, and extensive assist in the morning. On July 12, 2023, at 8:03 a.m., the surveyor observed ULP-E provide morning cares to R4 in her apartment. R4 was in bed, lying on her back. The horizontal blinds were open, and an adjacent building was visible from the windows, with open blinds. ULP-E lowered the blankets from R4, removed the incontinent brief, placed a clean brief and pants up to R4's knees, and assisted her to sit on the edge of the bed. ULP-E attached the sling to the standing lift, and assisted R4 to the standing position, with her exposed buttocks facing the windows with the open blinds, and brought R4 to the bathroom in the standing lift. On July 12, 2023, at 9:05 a.m., ULP-E stated she should have closed the blinds in R4's room prior to beginning the morning cares. On July 12, 2023, at 9:10 a.m., registered nurse (RN)-D stated staff should provide privacy and close the blinds when providing cares. The licensee's Bill of Rights for Assisted Living policy dated updated July 12, 2023, noted residents would have the rights to personal and treatment privacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *07/12/23*
Time: 12:26:45
Report: 7994231138

Food and Beverage Establishment Inspection Report

Location:

Folkestone North
100 Promenade Avenue
Wayzata, MN55391
Hennepin County, 27

Establishment Info:

ID #: 0038575
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522492400
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

3-501.16A1 ***** Priority 1 *****

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

SOME HOT FOODS IN THE TWO SATELLITE KITCHENS WERE FOND BELOW 135 F. THESE FOODS WERE ABOVE 135 WHEN LEAVING THE MAIN KITCHEN AND WILL BE SERVED WITHIN 4 HOURS.

Comply By: 07/12/23

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

HANDWASH SINK SINK ON FLOOR 5 WAS FOUND BLOCKED BY A GARBAGE CAN. MANAGER MOVED GARBAGE DURING INSPECITON

Comply By: 07/12/23

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

TEMPERATURES:
MAIN KITCHEN

TOMATOES 41
JUICE 40
MILK 39
SALSA 38

PORK CHOP 148
POTATO 145

SERVICE KITCHENS
PORK CHOPS 125*
PORK CHOP 132*
POTATOES 128*
POTATOES 129*

FISH 138
SAUCE 145

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 7994231138 of 07/12/23.

Certified Food Protection Manager: Joseph Aaron Kaplan

Certification Number: 18250 Expires: 10/27/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994231138

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/12/23
Time In 12:26:45
Time Out

	Address	City/State	Zip Code	Telephone
Folkestone North	100 Promenade Avenue	Wayzata, MN	55391	9522492400

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038575		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

Compliance Status		COS	R
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	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 07/12/23

Inspector (Signature) Crystal Elva