Electronically Delivered

July 28, 2023

Licensee
York Gardens Senior Living
3451 Parklawn Avenue
Edina, MN 55435

RE: Project Number(s) SL30779015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 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
	30779	A. BUILDING: _____ B. WING _____	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK GARDENS SENIOR LIVING	3451 PARKLAWN AVENUE EDINA, MN 55435

(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 the Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30779015 On July 10, 2023, through July 12, 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 68 active residents; 65 receiving services under the Assisted Living/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.	
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	0 480		

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0 480	Continued From page 1 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 10, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that 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.	0 510		

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0 510	Continued From page 2 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 10, 2023, at 11:50 a.m., in the secured memory care unit, surveyor observed unlicensed personnel (ULP)-C administer medications to R7. ULP-C degloved and failed to perform hand hygiene prior to going into R6's room for a medication administration. ULP-C failed to complete hand hygiene before or after medication administration to R6. On July 10, 2023, at approximately 1:30 p.m., ULP-D entered R3's room to provide medication administration on R3. ULP-D failed to perform hand hygiene prior to R3's medication administration.	0 510		

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0 510	Continued From page 3 On July 10, 2023, at approximately 1:50 p.m., ULP-D completed medication administration with R3 and proceeded to R4's room. ULP-D failed to perform hand hygiene after exiting R3's room, prior to entering R4's room, and after exiting R4's room. On July 11, 2023, at 9:05 a.m., surveyor observed wound care for R5 in resident room. Licensed practical nurse (LPN)-G unwrapped the dirty wound dressing for R5 and placed it on the ground and failed to use a barrier or trash can for the dirty dressing. LPN-G threw the dirty dressing in the trash after wound care was complete. On July 10, 2023, at approximately 2:30 p.m., clinic nursing supervisor (CNS)-B indicated all staff should be performing hand hygiene prior to entering resident rooms and after exiting resident rooms. On July 11, 2023, at 1:00 p.m., CNS-B stated the licensee's policy for wound care is based on good infection control with hand washing, gloving properly and placing all dirty dressings either on a barrier or directly in the garbage can and never directly on the floor. The licensee's Standard Infection Control Precautions policy dated August 1, 2022, indicated staff would perform hand hygiene between all client contacts. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 700	Continued From page 4	0 700		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all sixty-five (65) residents residing in the facility receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 10, 2023, at 11:00 a.m., the surveyor observed an opened and unattended lap top computer sitting on a desk in the fourth-floor nursing office with the door open and unattended. The computer screen displayed R3's electronic medication administration record (eMAR). On July 10, 2023, at 11:50 a.m., the surveyor observed unlicensed personnel (ULP)-C	0 700		

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0 700	Continued From page 5 medication pass for R7. ULP-C left the computer screen open while she left for the resident's room to give her the medications. R7's eMAR was open on the medication cart in a common area and left unattended for 5 minutes. On July 10, 2023, at 12:00 p.m., the surveyor observed ULP-C medication pass for R6. ULP-C left the computer screen open while she left for the resident's room to give medications. R6's eMAR was open on the medication cart in a common area and left unattended for 5 minutes. On July 10, 2023, at 11:01 a.m., clinical nurse supervisor (CNS)-B stated she also saw the open laptop and laptop computer screens were to be closed when not in use, resident information should not be visible. CNS-B then closed the laptop screen. On July 10, 2023, at 12:05 p.m., ULP-C stated computer screens and resident information were not to be left in the open for other people to see, all resident information should be protected. The licensee's Resident Record-Confidentiality policy revised August 1, 2021, indicated resident records would be kept confidential and locked in a secure area where only authorized staff of the facility had access to. No further information provided.	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 6 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 780		

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0 780	Continued From page 7 a large portion or all of the residents). Findings include: On July 11, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A and Environmental Services Director (ESD)-E. During the facility tour, it was observed that in the 2-bedroom units 214 and 410, the bedroom that was equipped with smoke alarms was not interconnected with the other bedroom smoke alarms in the same unit, so that actuation of one bedroom alarm would cause all alarms to operate. This deficient condition was visually verified by LALD-A and ESD-E accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of	0 800		

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0 800	Continued From page 8 the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 11, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-A and Environmental Services Director (ESD)-E. During the facility tour, survey staff observed the following: In the lounge in the memory care, it was observed that there was a considerable brown stain on the acoustic ceiling tile with evidence of water damage. During the interview, ESD-E stated that the heat pump in the ceiling leaked, and they planned to repair it. In the office suite and conference room on the first floor, it was also observed that the doors were propped open with a rubber wedge. Those doors were fire-rated, and the rubber wedge will prevent the door from closing in the event of a fire. In the activity space in the memory care, it was observed that the fireplace mesh screen was ripped and exposed with sharp edge. In the theater on the second floor, it was also observed that the two doors were propped open	0 800		

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0 800	Continued From page 9 with a rubber wedge. Those doors were fire-rated, and the rubber wedge will prevent the door from closing in the event of a fire. In the restroom near the resident's unit 313 on the third floor, it was observed that the door closer had been disabled by removing the closure arm or closure device. The door had a portion or remnants of the closure device still mounted on the door. The door closure device is required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes. It was also observed that the door was a power-assisted accessible door, but the automatic door opening function was disconnected. In resident unit 410 on the fourth floor, it was observed that the door did not close and self-latch when tested. The door is required to automatically close and latch to maintain the fire barrier of the room. In the restroom near the resident's unit 417 on the fourth floor, it was observed that the door closer had been disabled by removing the closure arm or closure device. The door had a portion or remnants of the closure device still mounted on the door. The door closure device is required to make the door close and positively latch to maintain the fire integrity of the resident room and corridor for safety purposes. It was also observed that the door was a power-assisted accessible door, but the automatic door opening function was disconnected. In the laundry room on the fourth floor, it was observed that the door did not close and self-latch. The fire-rated door is required to automatically close and latch to maintain the fire	0 800		

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0 800	Continued From page 10 barrier of the room. During the facility tour, LALD-A and ESD-E visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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 resident handbook did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 970		

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0 970	Continued From page 11 The findings include: On July 10, 2023, at approximately 11:30 a.m., licensed assisted living director (LALD)-A provided a blank Assisted Living Contract and indicated the document was the licensee's assisted living contract signed by all residents who lived in the facility. Additionally, LALD-A provided the licensee's Resident Handbook, and indicated all residents agree to the contents of the guide by signing the Assisted Living Contract. The licensee's Resident Handbook dated March 2022, on page 15, included a section titled Insurance and read, "Neither Owner nor Management Agent are responsible for your personal belongings." On July 10, 2023, at approximately 3:00 p.m., LALD-A acknowledged the licensee's resident handbook did indicate the licensee was not liable for residents' personal property. LALD-A indicated the language would need to be removed as current language did waive the licensee's liability for the residents' personal property. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060		

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	30779	A. BUILDING: _____ B. WING _____	07/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK GARDENS SENIOR LIVING	3451 PARKLAWN AVENUE EDINA, MN 55435

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01060	Continued From page 12 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	01060		

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01060	Continued From page 13 licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative, and the Office of Long-Term Care (OOLTC) for one of one resident (R2) who had an emergency relocation. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on September 8, 2022. R3's Progress Notes dated June 22, 2023, at 9:26 a.m., indicated R3 was transported and admitted to the hospital. R3's Progress Notes dated June 26, 2023, at 3:07 p.m., indicated R3 returned from the hospital. R3's record lacked documentation licensee provided an emergency relocation written notification as required to the resident, legal representative, designated representative, and the OOLTC. On July 11, 2023, at approximately 12:30 p.m., licensed assisted living director (LALD)-A indicated the licensee was aware of the required content of an emergency relocation notice, but the licensee had not provided the notice to R3's	01060		

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01060	Continued From page 14 legal representative, or designated representative, and Ombudsman when the emergency relocation was longer than four days. The licensee's Resident Agreement Termination-Emergency Relocation policy dated August 2021, indicated the required written notice with the required content for an emergency relocation would be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of	01640		

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01640	Continued From page 15 the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by resident or resident representative to document agreement on the services to be provided for three of six residents (R3, R7, R8). 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: R3 R3 was admitted on September 8, 2022. R3's Service Plan Agreement signed September 24, 2022, was identified by clinical nurse supervisor (CNS)-B as R3's most current authenticated service plan. R3's unsigned Service Plan Agreement dated July 10, 2023, was provided by CNS-B, and indicated as R3's current service plan with services R3 was receiving. The service plan included 13 identified services which were revised after R3's signed service plan dated September 24, 2022. R7	01640		

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01640	Continued From page 16 R7 was admitted to licensee on July 1, 2021, under the previous comprehensive license and started receiving assisted living services on August 1, 2021. R7's unsigned Service Plan Agreement dated June 1, 2023, was identified by clinical nurse supervisor (CNS)-B as R7's most current service plan and identified as R7's current service plan with services R7 was receiving. R7's chart lacked a signed service plan agreement from the time of admission on July 1, 2021. R8 R8 was admitted to licensee on June 24, 2019, under the previous comprehensive license and started receiving assisted living services on August 1, 2021. R8's Service Plan Agreement dated July 11, 2023, with signature of July 10, 2023, was identified by CNS-B as R8's most current authenticated service plan and indicated as R8's current service plan with services R3 was receiving. The service plan included 10 identified services which were revised after R8's signed service plan dated April 14, 2023. On July 10, 2023, at approximately 11:00 a.m., CNS-B indicated the licensee's expectation is all service plans are signed by the RN who completed the document and then the resident or the resident's designated representative. CNS-B indicated licensee had completed R3's service plan but has not obtained R3's authentication. On July 11, 2023, at 1:00 p.m., CNS-B stated R7's unsigned service plan agreement dated June 1, 2023, was the current service plan and license lacked any signed service plan agreement	01640		

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01640	Continued From page 17 in the chart since the start of services on July 1, 2021. CNS-B stated this resident has a court appointed guardian and it has been difficult to get a signature from guardian. On July 11, 2023, at 1:30 p.m., CNS-B brought in R7's Service Plan agreement dated June 1, 2023, with resident signature from July 11, 2023. On July 11, 2023, at 2:15p.m., LALD-A stated all authentication or signatures for R7 must be done by the court appointed guardian. LALD-A presented surveyor with guardianship paperwork. On July 11, 2023, at 1:00 p.m., CNS-B stated Service Plan agreement dated July 11, 2023, for R8 was created today and signed today by designated representative for R8 to match the current services resident was receiving. The licensee's Service Plan Agreement Development and Revision policy dated August 1, 2021, indicated any changes to the resident's service plan or agreement must be signed by the resident or the resident's representative and the licensee's representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for three of five residents (R6, R7, R8). 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: R6 R6's service plan dated January 4, 2023, indicated R6 received monthly vital sign review, activities reminders, physical assist with bathing, re-orientation, dining set up, reminders to wear glasses, physical assistance with dressing, podiatry care, nail care, cueing for oral care, cueing for grooming, nurse assessments, housekeeping, laundry, medication check, medication administration, physical assistance with ambulation, physical assistance with bed mobility, escorts to and from meals, safety checks, toileting and skin checks. R6's Medication Management Plan (MMP) dated January 4, 2023, indicated medications being managed by the facility would be securely locked with limited access to authorized personnel.	01880		

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01880	Continued From page 19 R6's Comprehensive Assessment dated March 30, 2023, indicated R6 does not self-administer any medications. On July 10, 2023, at 12:00 p.m., in the secured memory care unit, the surveyor observed Calmoseptine lotion, butt paste, and neuriterx cream on R6's bathroom counter unlocked and unsecured while observing the medication pass in resident's room. R7 R7's unsigned service plan dated June 1, 2023, indicated R7 received activity reminders, cueing with bathing, reminders for meals, reminders for dressing, nailcare, oral care set up, grooming set up, monthly vitals, escort to and from meals, elopement risk and monitoring, housekeeping, laundry, medication administration, safety checks, reminders for toileting, medication maintenance, nursing assessments, and monthly medication check. R7's MMP dated June 1, 2023, indicated medications being managed by the facility would be securely locked with limited access to authorized personnel. The MMP also indicated the resident does not self-administer any medications. On July 10, 2023, at 12:00 p.m., in the secured memory care unit the surveyor observed Calmoseptine lotion on R7's bathroom counter unlocked and unsecured while observing the medication pass in resident's room. R8 R8's unsigned service plan dated July 11, 2023, indicated R8 received activity reminders, assistance with bathing, behavior management,	01880		

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01880	Continued From page 20 orientation assistance, dressing assistance, reminders to use glasses, grooming set up, oral care set up, high fall risk, escorts to and from meals, stand by assist of one for transfers, monthly vitals, nursing assessments, housekeeping, laundry, medication administration, monthly medication check, safety checks, fall risk wandering monitoring, and skin checks. R8's MMP dated July 11, 2023, indicated medications being managed by the facility would be securely locked with limited access to authorized personnel. The MMP also indicated the resident does not self-administer any medications. On July 11, 2023, at 8:30 a.m., in the secured memory care unit, the surveyor observed Fluticasone propionate spray and Kirkland Vitamin D3 50 mcg on R8's bathroom counter unlocked and unsecured while observing morning cares in resident's room. On July 10, 2023, at 12:05 p.m., unlicensed personnel (ULP)-C stated staff were not to keep any medications at the bedside in the secured memory care. She further stated that she does see medicated creams at almost all of the residents' bedsides. On July 11, 2023, at 1:00 p.m., clinical nurse specialist (CNS)-B stated no medications were to be kept at the bedside or bathrooms of the secured memory care unit. CNS-B stated that sometimes family bring in over the counter medications to residents' rooms without checking with staff first. CNS-B stated the licensee would be doing a sweep of the entire unit to check for medications to be locked up.	01880		

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01880	Continued From page 21 The licensee's Storage of Medication and Key Security policy updated April 19, 2023, indicated a nursing assessment of a clients need for medication management services, including the appropriate way to store the residents' medications whether a secured storage is appropriate given the clients functional and cognitive status. Based on the assessment the nurse will develop an individualized medication management plan for the client and will address storage of the residents' medications. Definitions: Secured Storage of medication is defined as medications stored in a locked cabinet/box. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the	02040		

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02040	Continued From page 22 licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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). Findings include: A record review of the available documentation and interview was conducted on July 11, 2023, at approximately 1:00 p.m., with the Licensed Assisted Living Director (LALD)-A and Environmental Services Director (ESD)-E on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During the interview, LALD-A stated that the licensee received a hazard vulnerability assessment template from their corporate office but had yet to perform a facility-specific hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Type: Full
Date: *07/10/23*
Time: 10:30:00
Report: 1005231121

Food and Beverage Establishment Inspection Report

Location:
York Gardens Senior Living
3451 Parklawn Avenue
Edina, MN55435
Hennepin County, 27

Establishment Info:
ID #: 0038476
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528986700
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

THERE IS AN ACCUMULATION OF FOOD DEBRIS ON THE FLOOR OF THE WALK-IN COOLER.

Comply By: 07/17/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3-COMP DISPENSER
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/CHEESE SAUCE
Temperature: 165 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Hot Hold/PHILLY STEAK
Temperature: 190 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/CHEESE
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

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

Process/Item: Hot Hold/SOUP
Temperature: 179 Degrees Fahrenheit - Location: METRO WARMING CABINET
Violation Issued: No

Process/Item: Cold Hold/PORK
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BEEF
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/POTATOES
Temperature: 34 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BUTTER
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/AMBIENT
Temperature: 41 Degrees Fahrenheit - Location: DELFIELD UPRIGHT COOLER #3
Violation Issued: No

Process/Item: Hot Hold/SOUP
Temperature: 196 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

Process/Item: Cold Hold/BUTTER
Temperature: 41 Degrees Fahrenheit - Location: SERVER UNDER COUNTER COOLER
Violation Issued: No

Process/Item: Cold Hold/YOGURT
Temperature: 34 Degrees Fahrenheit - Location: 4TH FLOOR KITCHENETTE COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: 1ST FLOOR KITCHENETTE COOLER
Violation Issued: No

Type: Full
Date: *07/10/23*
Time: 10:30:00
Report: 1005231121
York Gardens Senior Living

Food and Beverage Establishment Inspection Report

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

INSPECTION COMPLETED WITH KITCHEN MANAGER AND REVIEWED WITH HRD NURSE EVALUATOR, CARL SAMROCK.

DISCUSSED ORDER ON REPORT, AS WELL AS COOLING, DATE-MARKING, COOK TEMPERATURES, AND EMPLOYEE ILLNESS.

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 1005231121 of 07/10/23.

Certified Food Protection Manager: DAVID J. LAVOIE

Certification Number: FM44362 Expires: 09/07/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
DAVE LAVOIE
KITCHEN MANAGER

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us