Electronically Delivered

July 6, 2023

Licensee
English Rose Suites
6200 Loch Moor Drive
Edina, MN 55439

RE: Project Number(s) SL34598015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 3, 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,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 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
	34598	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLISH ROSE SUITES	6200 LOCH MOOR DRIVE EDINA, MN 55439

(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 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: SL34598015-0 On, May 1, 2023, through May 3, 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 six (6) residents, all of whom received services under the provider's Assisted Living licensewith Dementia Care license..	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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 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 evaluators' 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 May 2, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 2 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 interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees, director of nursing, (DON)-B. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 650		

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0 650	Continued From page 3 DON-B was hired on June 20, 2021, to oversee the nursing program and resident care as well as administrative tasks. DON-B also routinely provided direct cares and services to residents in the facility. DON-B's employee record lacked an annual performance review that identified areas of improvement needed and training needs. On May 4, 2023, at 1::00 p.m. during exit conference, the licensed assisted living director (LALD)-A stated it was the licensee's standard to complete an annual performance review on each employee. LALD-A stated although she believed DON-B's annual performance review was completed on time, it was not filed appropriately and was unable to locate the document. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 4 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's comprehensive emergency preparedness plan lacked the following required content: - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response.	0 680		

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0 680	Continued From page 5 - process for arrangements with other facilities/providers to receive residents in the event of limitation/cessation of operations to maintain the continuity of services to residents. - policies and procedures on volunteers. On May 4, 2023, at 1:30 p.m., licensed assistant living director (LALD)-A stated the licensee's emergency preparedness plan lacked the above listed required content, and stated licensee was not aware of all the required content of Appendix Z. The licensee's Disaster Planning and Emergency Preparedness Planning policy dated August 2021, indicated the licensee would have in place a general emergency preparedness plan, that was in alignment with facility's requirement to also comply with CMS (Centers doe Medicare and Medicaid Services) Appendix Z.	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810		

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0 810	Continued From page 6 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide fire protection procedures necessary for residents, failed to provide required employee training on fire safety and evacuation, and failed to provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire or similar emergency. This had the potential 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	0 810		

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0 810	Continued From page 7 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on May 2, 2023, at approximately 1:00 p.m. with the Director of Maintenance (DM)-D on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview, DM-D indicated the fire safety and evacuation plan lacked fire protection procedures for the resident. Record review indicated that employees did not receive training twice per year after initial hire. During the interview, DM-D stated that the licensee provided annual training to employees, but not twice per year after the initial hire on the fire safety and evacuation plan, as required by statute. A policy was requested on employee training, and one was provided indicating that the licensee only provides annual training. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire or similar emergency. Provided documentation had no policies or records of documented resident training. During the interview, DM-D was unable to locate these procedures and verified that the plan lacked these provisions.	0 810		

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0 810	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 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.	01470		

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01470	Continued From page 9 (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 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 provide orientation to assisted living licensing requirements and regulations prior to providing services for one of two employees director of nursing (DON-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01470		

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01470	Continued From page 10 The findings include: DON-B was hired on June 20, 2021, to oversee the nursing program and resident care as well as administrative tasks. DON-B also routinely provided direct cares and services to residents in the facility. DON-B's employee record lacked documentation of orientation to assisted living regulations as follows: -reporting maltreatment of vulnerable adults or minors -consumer advocacy services -review of types of assisted living services the employee would provide and provider's scope of license -principles of person-centered planning/service delivery -hearing loss training (optional) -orientation to each specific resident and services provided On May 4, 2023, at 1::00 p.m. during exit conference, the licensed assisted living director (LALD)-A stated the licensee expected all orientation to be completed prior to that employee working directly with residents. LALD-A further explained the licensee was moving to an electronic healthcare record and expected the transfer to have more reliable results for record keeping and training completed in a timely manner. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		

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01480	Continued From page 11	01480		
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to each resident for one of two employees unlicensed personal (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: On May 2, 2023, between 9:00 a.m. and 9:30 a.m., the surveyor observed ULP-E assist a resident (R--1) with morning cares, transfer with a Hoyer lift (a hydraulic lift used with a sling to safely transfer residents), catheter care (flexible tube that a clinician passes through the urethra and into the bladder to drain urine) and provide medication administration ULP-E was hired on May 27, 2022, to provide direct care and services to residents in the facility.	01480		

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01480	Continued From page 12 ULP-E's employee record lacked documentation of orientation to each resident and services to be provided. On May 4,2023, at 1:00 p.m., the licensed assisted living director, (LALD-A) stated the licensee's process to orientate employees to each resident was an electronic system top review each resident's plan of care. After an employee reviewed the care plan, an "acknowledgement" button was to "be clicked on." LALD-A stated if this was not completed, it would disappear. LALD-A stated it was a "glitch in the system" that needed to be addressed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01480		
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	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34598	A. BUILDING: _____ B. WING _____	05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENGLISH ROSE SUITES	6200 LOCH MOOR DRIVE EDINA, MN 55439

(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
01500	Continued From page 13 gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01500		

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	34598	A. BUILDING: _____ B. WING _____	05/04/2023

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01500	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training on the required topics for each 12 months of employment for one of two employee's, the director of nursing, (DON-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: DON-B was hired on June 20, 2021, to oversee the nursing program and resident care as well as administrative tasks. DON-B also routinely provided direct cares and services to residents in the facility. DON-B's employee record lacked documentation of 8 hours of annual training completed within the last year, including the following required topics: - reporting maltreatment of vulnerable adults or minors - assisted living bill of rights - review of provider's policies and procedures - principles of person-centered planning/service delivery - hearing loss training (optional) - dementia training met two (2) hours annually In addition, DON-B's employee record did not indicate amount of time for training received.	01500		

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	34598	A. BUILDING: _____ B. WING _____	05/04/2023

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01500	Continued From page 15 On May 4, 2023, at 1::00 p.m. during exit conference, the licensed assisted living director (LALD-A) stated, the problem was the way the licensee documented training hours: the licensee did not break it out by time, but instead only by topic. LALD-A explained all employees working in the facility were required to complete eight (8) hours of annual training according to the new licensure effective in August 2021. LALD-A stated she was aware DON-Bs employee record lacked the indicated required topics: No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an	01650		

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	34598	A. BUILDING: _____ B. WING _____	05/04/2023

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01650	Continued From page 16	01650		

emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure resident service plans included the required content for one of two residents (R-1).

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

The findings include:

R1 was admitted on October 11, 2021. R1's diagnoses included late-onset Alzheimers disease (primary), fatigue, repeated falls, atherosclerotic heart disease, weakness, urinary tract infection with current indwelling catheter.

R1's service plan, signed and dated November 3, 2022, indicated R1 received services to include medication management, personal care including dressing, oral hygiene, shaving, hair care,

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	34598	A. BUILDING: _____ B. WING _____	05/04/2023

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01650	Continued From page 17	01650		

make-up, nail care, housekeeping, laundry, bathing assistance, shampoo, foot soaks, Hoyer lift transfer (a mobile floor lift system on wheels and intended to help lift, suspend and transfer a medically dependent person), therapeutic exercise, feeding, and toileting/ catheter care.

The Clinical Update Assessment/ 90 day assessment completed by a registered nurse (RN-C), indicated R1 would be:
-repositioned every 2 hours and as needed, to prevent skin breakdown by a ULP.
-active ROM (range of motion) to keep joints mobile completed by ULP two times daily.
-provided all housekeeping services dally and as needed.
-performed all laundry services and housekeeping as scheduled as needed.
-to change bed linens weekly and as needed.

R1's Resident Plan of Care, effective date, May 1, 2023 indicated R1 recieved exercise daily, foot soaks bi-weekly, linen change on Thursdays, aroma therapy daily,
bed bath on Monday and Thursday, position and reposition every two hours, safety checks at start and througout the shift, toileting and incontinence care every two hours.

R1's service plan, dated and signed November 3, 2022, lacked laundry and housekeeping services, linen change and activities.In addition R1's service plan did not include:
-a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;
-the identification of staff or categories of staff who will provide the services;
-the schedule and methods of monitoring

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01650	Continued From page 18 assessments of the resident; -the schedule and methods of monitoring staff providing services - a contingency plan that included the action to be taken if the scheduled service cannot be provided, information and a method to contact the facility, the names and contact information of persons the resident wishes to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and the circumstances in which emergency medical services are not to be summoned. On May 4, 2023, at 1:00 p.m., the licensed assisted lvng director (LALD-A) stated R1's service plan did not contain all the requuired content including frequency, methods of monitoring and emergency medical services. LALD-A stated the licensee was in the process of implementing the R-Tasks format for an electronic health record system. LALD-A stated it "was a work in progress" and expected the service planto be complete and accurate. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		

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

Type: Full
Date: *05/02/23*
Time: 10:00:00
Report: 1005231085

Food and Beverage Establishment Inspection Report

Location:
English Rose Suites
6200 Loch Moor Drive
Edina, MN55439
Hennepin County, 27

Establishment Info:
ID #: 0038980
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529830412
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.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

EMPLOYEE HAD CERTIFICATE FROM FOOD SAFETY TRAINING COURSE POSTED, BUT NOT THE MN CERTIFIED FOOD PROTECTION MANAGER (CFPM) CERTIFICATE. POST THE MN CFPM CERTIFICATE.

Comply By: 05/09/23

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/HOT DOG
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/BACON
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CANTALOUPE
Temperature: 39 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Type: Full
Date: *05/02/23*
Time: 10:00:00
Report: 1005231085
English Rose Suites

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/CHEESE
Temperature: 41 Degrees Fahrenheit - Location: BASEMENT REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH FOOD MANAGERS AND REVIEWED WITH HRD NURSE EVALUATOR, MARY BRUESS.

DISCUSSED ORDER ON REPORT AS WELL AS DATE-MARKING, FOOD TEMPERATURES, GLOVE USE, EMPLOYEE ILLNESS, AND SANITIZING.

TEMPERATURE INDICATING STRIPS WERE AVAILABLE FOR CHECKING THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHER. MANAGER STATES THEY USE THEM ONCE A MONTH AND THEY REACH AT LEAST 160 DEGREES F.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE. FLOORING IS TILE, CABINETS ARE WOOD WITH A SOLID BASE, COUNTERS ARE GRANITE AND THE CEILING IS A SMOOTH, PAINTED SHEETROCK.

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 1005231085 of 05/02/23.

Certified Food Protection Manager: JOLYNN D. ERICKSEN

Certification Number: FM111365 Expires: 08/14/25

Signed: _____
JOLYNN ERICKSEN

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