Electronically Delivered

March 15, 2023

Licensee
The Glenn Minnetonka
5300 Woodhill Road
Minnetonka, MN 55345

RE: Project Number(s) SL28261015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 2, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

**LICENSING ORDERS**
The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 evaluation of your facility**.

**DOCUMENTATION OF ACTION TO COMPLY**
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

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

Please email 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-281-9796

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 28261 | A. BUILDING: _____ B. WING _____ | 02/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE GLENN MINNETONKA | 5300 WOODHILL ROAD MINNETONKA, MN 55345 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL28261015-0<br><br>On January 30, 2023, through February 2, 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 76 residents, all of whom received services under the provider's Assisted Living with 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 650 SS=D | 144G.42 Subd. 8 Employee records | 0 650 | | |

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| 0 650 | Continued From page 1<br><br>(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:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(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<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the employee record included a current job description, including qualifications, responsibilities, for one of two employees (unlicensed personnel (ULP)-E).<br><br>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 | 0 650 | | |

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| 0 650 | Continued From page 2<br>limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-E was hired February 26, 2015, and provided direct cares for the residents of the facility.<br><br>On January 31, 2023, at 8:10 a.m., ULP-E was observed administering medications to R3.<br><br>ULP-E's employee record lacked a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision.<br><br>On February 01, 2023 at 11:20 a.m. Executive Director (ED)-A verified ULP-E's record lacked evidence of current job description with required content.<br><br>The licensee's Personnel (employee) Records policy dated July 29, 2021, noted an employee record for each employee would include current job description, which included qualifications, responsibilities and identification or supervisors.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire | 0 790 | | |

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| 0 790 | Continued From page 3<br>Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the ability to affect all staff, residents, and visitors.<br><br>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).<br><br>Findings include:<br><br>On February 1, 2023, between 11:00 a.m. and 1:45 p.m., survey staff toured the facility with the executive director (ED)-A. During the facility tour, survey staff observed portable fire extinguishers with service tags dated October 2021.<br><br>This deficient condition was verified by ED-A accompanying on the facility tour. | 0 790 | | |

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| 0 790 | Continued From page 4<br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>Findings include:<br><br>On February 1, 2023, between 11:00 a.m. and 1:45 p.m., survey staff toured the facility with the | 0 800 | | |

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| 0 800 | Continued From page 5<br>executive director (ED)-A. During the facility tour, survey staff observed a door leading to a courtyard had an exit sign posted over it, but the snow had not been cleared for a path of egress. All paths of egress must be maintained and clear of obstructions to allow residents, staff, and visitors to exit the building in a safe and efficient manner in the event of an emergency.<br><br>This deficient condition was verified by ED-A accompanying on the facility tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(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.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(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<br>(5) a statement that, if the facility refuses to | 01060 | | |

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| 01060 | Continued From page 6<br>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.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(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.<br>(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<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation when hospitalized, for two of two residents (R4, R7).<br><br>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).<br><br>The findings include: | 01060 | | |

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| 01060 | Continued From page 7<br><br>R4 and R7's records lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum:<br>- the reason for the relocation;<br>- the name and contact information for the location to which the resident had been relocated and any new service provider;<br>- contact information for the Office of Ombudsman for Long-Term Care (OOLTC);<br>- if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and<br>- a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal.<br><br>R4<br>R4 was admitted for services on May 15, 2022, with diagnoses including but not limited to type 2 diabetes mellitus with unspecified diabetic retinopathy without macular edema, paroxysmal atrial fibrillation, unspecified dementia without behavioral disturbances, chronic kidney disease stage 3, generalized anxiety disorder, and essential (primary) hypertension.<br><br>R4's Service Plan effective January 31, 2023, indicated R4 received services including assistance with medication administration, dressing, grooming, and toileting.<br><br>R4's discharge orders dated January 23, 2023, at 6:18 p.m., indicated R4 was admitted to the hospital on January 5, 2023, for unspecified fracture of fourth thoracic vertebra. | 01060 | | |

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| 01060 | Continued From page 8<br><br>R4's Resident Progress Note dated January 24, 2023, at 3:52 p.m., indicated R4 was re-admitted to the assisted living with dementia care facility from a rehabilitation center on January 24, 2023.<br><br>R4's record lacked evidence of R4, the residents' legal representative, and designated representative were provided with a written notice including the required content for an emergency relocation and lacked evidence of notification to the Office of Ombudsman for Long-Term Care when R4 did not return to the facility within four days, as required.<br><br>On January 31, 2023, at 1:51 p.m., interim director of clinical services (IDCS)-B stated they were unaware the facility needed to provide a written notice with the required content for an emergency relocation to the resident, the residents' legal representative, and designated representative, as required.<br><br>R7<br>R7 was admitted for services on December 20, 2019, with diagnoses including but not limited to major depressive disorder, recurrent, moderate, unspecified essential hypertension, hypothyroidism, hypothyroidism, iron deficiency anemia, and history of breast cancer.<br><br>R7's Service Plan effective January 31, 2023, indicated R7 received services including assistance with medication administration, dressing, grooming, toileting, and transferring,<br><br>R7's discharge orders dated January 29, 2023, at 8:26 a.m., indicated R7 was admitted to the hospital on January 24, 2023, for hypoxia and acute pulmonary edema secondary to aspiration pneumonia. R7's discharge orders indicated R7 | 01060 | | |

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| 01060 | Continued From page 9<br>would return to the assisted living facility with dementia care on January 29, 2023.<br><br>R7's Resident Progress Note dated January 24, 2023, at 3:52 p.m., indicated R4 was re-admitted to the assisted living with dementia care facility from a rehabilitation center on January 29, 2023.<br><br>R7's record lacked evidence of R7, the residents' legal representative, and designated representative were provided with a written notice including the required content for an emergency relocation and lacked evidence of notification to the Office of Ombudsman for Long-Term Care when R7 did not return to the facility within four days, as required.<br><br>On January 31, 2023, at 1:51 p.m., interim director of clinical services (IDCS)-B stated they were unaware the facility needed to provide a written notice with the required content for an emergency relocation to the resident, the residents' legal representative, and designated representative.<br><br>The licensee's Emergency Relocation policy, reviewed January 12, 2023, indicated the facility may remove a resident from the facility in an emergency if necessary due to the resident's urgent medical needs or an imminent risk the resident posed to the health or safety of another facility resident or staff member, and in the event of an emergency relocation, would provide a written notice that contained the above required content. The notice would be delivered as soon as practicable to the resident, legal representative, and designated representative, and the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. | 01060 | | |

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| 01060 | Continued From page 10<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01060 | | |
| 01440 SS=D | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of | 01440 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01440 | Continued From page 11<br>providing services for one of one employee (unlicensed personnel (ULP)-E.<br><br>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).<br><br>The findings include:<br><br>ULP-E was hired February 26, 2015, and provided direct cares for the residents of the facility.<br><br>ULP-E's record did not include documentation of direct supervision by an RN within 30 days of ULP-E performing delegated nursing tasks, including medication administration.<br><br>On January 31, 2023, at 8:10 a.m., ULP-E was observed administering medications to R3.<br><br>On February 01, 2023 at 11:20 a.m. Executive Director (ED)-A verified ULP-E's record does not include 30-day supervision of medication administration or other delegated tasks.<br><br>The licensee's Personnel Records policy dated July 29, 2021, noted personnel record for each person would include results of supervision observations, performance evaluations which identify areas of improvement needed and training needs.<br><br>No further information was provided. | 01440 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 28261 | A. BUILDING: _____ B. WING _____ | 02/02/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 01440 | Continued From page 12<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01440 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and record review, the licensee failed to ensure ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident for one of five residents (R1) . | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01620 | Continued From page 13<br><br>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).<br><br>The findings include:<br><br>R1 was admitted to the facility on January 03, 2020.<br><br>R1's Service Plan Agreement, dated July 06, 2022, indicated R1 received services for assistance with medication administration, and assistance with shower.<br><br>R1's record included progress note dated 07/30/2022 indicated "Resident was admitted to Fairview Southdale hospital on 7/22/2022" and discharged orders were faxed from Sholon Care on August 08, 2022.<br><br>R1's record included Uniform Assessment tool Quarterly dated June 06, 2022; August 28,22; November 15, 2022. R1 record lacked changing of condition assessment after resident returned from hospital on August 08, 2022.<br><br>On February 01, 2023 at 11:00 a.m., direct of nursing,(DON) - B verified nursing assessment was not completed after resident return from hospital on August 08, 2022.<br><br>No further information was provided. | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01620 | Continued From page 14<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01940 | Continued From page 15<br>by:<br>Based on interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R7).<br><br>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).<br><br>Findings include:<br><br>R7 was admitted for services on December 20, 2019, with diagnoses including but not limited to major depressive disorder, recurrent, moderate, unspecified essential hypertension, hypothyroidism, hypothyroidism, iron deficiency anemia, and history of breast cancer.<br><br>R7 was hospitalized on January 24, 2023, at 10:49 a.m., for hypoxia and acute pulmonary edema secondary to aspiration pneumonia.<br><br>R7's discharge orders dated January 29, 2023, at 8:26 a.m. R7's discharge orders indicated R7 would return to the assisted living facility with dementia care on January 29, 2023, with oxygen therapy.<br><br>R1's prescriber's signed orders dated January 29, 2023, included continuous oxygen therapy via nasal cannula at 1-2 liters per minute for comfort.<br><br>R7 lacked an Individualized Treatment and | 01940 | | |

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| 01940 | Continued From page 16<br>Therapy Management Plan for oxygen therapy.<br><br>On January 31, 2023, at approximately 2:30 p.m., interim director of clinical services (IDCS)-B acknowledged R7's record lacked a treatment management plan and that she would work to update the record.<br><br>The licensee's Individualized Medication, Treatment and Therapy Management Plans policy dated May 24, 2022, indicated the RN would develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services, and the plan would be current and updated when there were changes.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01940 | | |
| 02310 SS=D | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards for one of one resident (R7) with safe oxygen | 02310 | | |

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| 02310 | Continued From page 17<br>storage.<br><br>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).<br><br>On January 31, 2023, at 9:00 a.m., one oxygen tank cylinder was observed in R7's apartment, standing upright, and unsecured. R7's apartment door was observed to lack oxygen in use signage.<br><br>On January 31, 2023 @ 9:00 a.m., licensed practical nurse (LPN)-E stated resident was just placed on hospice January 30th, 2023, and the hospice nurse arranged for the oxygen placement in R7's apartment.<br><br>On January 31, 2023, at 9:56 a.m., executive director (ED)-A stated the oxygen tank cylinders should have been stored upright and secured to prevent the cylinders from falling over.<br><br>The licensee's policy titled, Safe Oxygen Use and Storage, dated August 28, 2021, indicated the registered nurse (RN) would ensure the resident has an appropriate storage cart or stand for the oxygen and oxygen containers would be secured in a stand or cart and always stored upright.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02310 | | |

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| | | | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *01/31/23*
Time: 08:26:23
Report: 1018231019

# Food and Beverage Establishment Inspection Report



**Location:**
The Glenn Minnetonka
5300 Woodhill Road
Minnetonka, MN55345
Hennepin County, 27

**Establishment Info:**
ID #: 0038976
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 7633771800
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.

No NEW orders were issued during this inspection.

## Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: BUCKET
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

## Food and Equipment Temperatures

Process/Item: Cold Holding/ EGGS
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ HAM
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ DELI MEAT
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ TOMATO
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Type: Full
Date: *01/31/23*
Time: 08:26:23
Report: 1018231019
The Glenn Minnetonka

# Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ CREAMER
Temperature: 40 Degrees Fahrenheit - Location: 2ND FLOOR COOLER
Violation Issued: No

Process/Item: Hot Holding/ MAC&CHEESE
Temperature: 170 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Hot Holding/ CHICKEN
Temperature: 160 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

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

INSPECTION CONDUCTED WITH HRD STAFF PRESENT.

DISCUSSED EMPLOYEE ILLNESS AND ILLNESS POLICIES.
DISCUSSED COOLING, COOK TEMPS, TEMPERATURE LOGS, DATE MARKING AND PEST CONTROL.

ESTABLISHMENT HAS THE MAIN KITCHEN AND TWO SATELLITE KITCHENS WITHIN THE FACILITY. SATELLITE KITCHENS ARE JUST USED FOR SERVING AT MEAL TIMES.

PASTEURIZED EGGS USED THROUGHOUT THE FACILITY.

NO ORDERS ISSUED.

**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 1018231019 of 01/31/23.

Certified Food Protection Manager CAROL A LUKANEN

Certification Number: FM70696 Expires: 02/10/25

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
CAROL A LUKANEN
KITCHEN MANAGER

Signed: _____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us