Electronically Delivered

April 5, 2022

Administrator
Gracepointe Crossing
1545 Riverhills Parkway Northwest
Cambridge, MN 55008

RE: Project Number(s) SL30763015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 18, 2022, 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.

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 . . ."

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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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 Department of Health 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 (a)(5)(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, no immediate fines are assessed.

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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should addressed 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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30763	A. BUILDING: _____ B. WING _____	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30763015 On March 15, 2022, through March 18, 2022, 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 71 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Licensed assisted living director (LALD)-F had a license effective through October 31, 2022; however, LALD-F's license lacked the licensee listed as the Director of Record with BELTSS. On March 15, 2022, at approximately 12:05 p.m., LALD-F stated she was not aware that she was not listed as the Director of Record for this facility and stated she would call BELTSS right away. On March 15, 2022, at approximately 2:40 p.m., LALD-F stated she had spoken to a representative from BELTSS and was assisted to	0 110		

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0 110	Continued From page 2 add the licensee as the Director of Record. This was verified on the BELTSS website by the surveyor at 2:45 p.m. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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	0 480		

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0 480	Continued From page 3 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 March 15, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the	0 500		

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0 500	Continued From page 4 assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, with records reviewed. 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 is 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).	0 500		

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0 500	Continued From page 5 The findings include: During entrance conference on March 15, 2022, at approximately 10:20 a.m., licensed assisted living director (LALD)-F and registered nurse (RN)-A stated they reviewed the current assisted living regulations online. The licensee failed to ensure the following policies and procedures were in place and kept current: - orientation, training, and competency evaluations of staff. On March 18, 2022, at approximately 8:05 a.m., regional clinical director (RCD)-G stated she was unable to locate a policy regarding the required contents of orientation, training and competency evaluations for staff. Review of the Education & Training Policy, revised August 2020 indicated the registered nurse (RN) would provide initial direction of a specific task and verify the unlicensed personnel (ULP) was trained and competent to perform the task, and included the RN designee was responsible for completing a performance review of each licensed and unlicensed staff annually at a minimum; however, the policy lacked direction for required content regarding orientation, training, and competency evaluations of staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 6 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post required information related to the licensee's grievance procedure to include the email contact information for the individual responsible for handling resident grievances. In addition, the licensee's posted grievance procedure lacked information to include the contact information for the state and applicable regional Office of Ombudsman for Long Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all 71 residents, staff 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 is 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).	0 550		

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0 550	Continued From page 7 The findings include: On March 15, 2022, at approximately 12:15 p.m., the surveyor observed the licensee's grievance procedure posted on a bulletin board in the entrance of the facility. The licensee lacked a posting to include all of the required content about the facility's grievance procedure to include the email contact of the individual responsible for handling resident grievances, the contact information for the state and applicable regional Office of Ombudsman for Long Term Care, and for the Office of Ombudsman for Mental Health and Developmental Disabilities, as required. On March 18, 2022, at approximately 8:05 a.m., licensed assisted living director (LALD)-F confirmed the required content noted above was not posted as required and stated the grievance procedure was posted prior to the assisted living licensure transition on August 1, 2022, and the forms were never updated. The licensee's Vulnerable Adult Abuse Prevention Plan policy, dated July 2021, indicated Quality Concern Forms were located at the household nursing area and were available for resident, resident representative, visitor, staff or vendor to complete; however, the policy lacked the content required to be included in the posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

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0 640	Continued From page 8 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all of the licensee's current residents, staff 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: The licensee failed to: - post the 911 emergency number in common areas and near telephones provided by the assisted living with dementia care facility.	0 640		

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0 640	Continued From page 9 On March 15, 2022, during the facility tour at approximately 12:15 p.m., the surveyor observed the entry area, common areas, near the house telephones and medication/charting areas within the facility and noted there was no posting of the 911 emergency number as required. On March 18, 2022, approximately 8:20 a.m., the regional clinical director (RCD)-G confirmed the 911 emergency information was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living	0 650		

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0 650	Continued From page 10 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for two of five employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-A RN-A had a hire date of November 23, 2010, and began providing services under the licensee's Assisted Living with Dementia Care license on August 1, 2021.	0 650		

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0 650	Continued From page 11 RN-A's record contained a Performance and Leadership Competency Feedback form, dated June 27, 2019; however, lacked any recent documentation of annual performance reviews that identified areas of improvement needed and training needs. On March 17, 2022, at approximately 10:19 a.m., licensed assisted living director (LALD)-F confirmed RN-A's employee record lacked an annual performance evaluation, as required. ULP-C ULP-C had a hire date of November 25, 1996, and began providing services under the licensee's Assisted Living with Dementia Care license on August 1, 2021. ULP-C's record lacked documentation of annual performance reviews that identified areas of improvement needed and training needs. On March 17, 2022, at approximately 10:20 a.m., LALD-F confirmed ULP-C's employee record lacked an annual performance evaluation, as required. The licensee's MN (Minnesota) AL (Assisted Living) Delegation and Supervision Policy, dated August 1, 2021, noted the RN designee was responsible for completing a performance review of each licensed and unlicensed staff annually at a minimum. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

(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
0 680	Continued From page 12	0 680		
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; and (5) have a written policy and procedure regarding missing tenant 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 have a written emergency preparedness (EP) plan with all of the required content. In addition, the licensee failed to provide the minimum frequency of inspection, maintenance and load test requirements for the emergency power generator as part of the EP plan to ensure proper performance of the	0 680		

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0 680	Continued From page 13 generator. This had the potential to affect all residents, staff 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 is 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: During the initial tour on March 15, 2022, at approximately 12:15 p.m., the surveyor observed the licensee's layout included a large building with a main level, lower level and upper level. The main level included resident rooms, a large common area, dining room, meeting rooms, and offices. The upper level included resident rooms. The lower level included The Arbor, which was a secured area for residents requiring memory care. An EP plan was posted in the main level common area, and emergency exit diagrams were posted on each floor and posted in residents' bedrooms on the inside of the door. The EP plan, undated, was in a red binder and was located in various areas throughout the facility, accessible to staff. The EP plan contained an introduction to emergency preparedness planning, information regarding developing an emergency plan, resources and planning tools, and directions for an actual emergency, including bomb threat, civil unrest, fire, flood, missing resident, nuclear threat, severe weather and utility failure. A facility risk assessment was included, as well as a site emergency contact list and contact	0 680		

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0 680	Continued From page 14 lists for local emergency and public safety partners, vendor directory, and contact information for state, national and federal public safety departments. The EP plan lacked the following required content: - procedures for tracking staff and residents; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies including surge planning and use of volunteers; - the facility's role in providing care and treatment at alternative sites; and - a communication plan that included: -primary and alternate means of communicating with facility staff and Federal, State, tribal, regional and local emergency management agencies. On March 16, 2022, at approximately 3:40 p.m., licensed assisted living director (LALD)-F verified the plan lacked the above content. On March 17, 2022, at approximately 1:10 p.m., survey staff received the emergency power generator records for review. The licensee failed to provide the minimum frequency of inspection, maintenance and load test requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's EP plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator: -Required weekly inspections of the generator	0 680		

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0 680	Continued From page 15 system. The last recorded inspection shown on the log, "Emergency Generator", was dated March 16, 2022, and no other prior monthly load test dates were shown on the log. -Required monthly generator load tests. The last recorded load test shown on the log, "Emergency Generator", was dated March 16, 2022, an no other prior monthly load test dates were shown on the log. -Required monthly transfer switch operation tests. The "Emergency Generator" log noted that no transfer tests were performed or activated. On March 17, 2022, at approximately 3:30 p.m., LALD-F, director of environmental services (DES)-H, and the regional director of environmental services (RDES)-J acknowledged the above findings. DES-H explained that they (licensee) have been performing weekly inspections and monthly load tests, but have not been logging them, and only logged in for the recent date of March 16, 2022, when they found out recently that the record keeping was necessary for assisted living. The licensee's Grace Point Crossing Emergency Operations Preparedness Plan, updated January 2022, included, "All emergency situations CANNOT be neatly defined into categories for which hard and fast guidelines can be drawn. Individual judgment must be exercised in given situations. Emergency procedures are designed to give guidelines to those having responsibility for the safety of residents, staff, volunteers, families and visitors." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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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: (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 maintain proper functioning of the smoke alarms in resident rooms #217 and # 320 as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect all assisted living residents, visitors, 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	0 780		

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0 780	Continued From page 17 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). On March 17, 2022, between the hours of 11:00 a.m. and 1:05 p.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-F, the director of environmental services (DES)-H, and the regional director of environmental services (RDES)-J. The findings include: RESIDENT ROOM #320 On March 17, 2022, at approximately 11:30 a.m., survey staff observed the smoke alarms in resident room #320 were tested by the DES-H and RDES-J, and both smoke alarms failed to sound. This finding was verified by RDES-J as he stated that the alarms appeared to be interconnected with a very low tone sound next to the smoke alarms, and agreed that they needed to be replaced. Survey staff explained that those alarms need to be replaced, be interconnected, as well as alarmed such as when the actuation of one smoke alarm causes both to sound for notification. RESIDENT ROOM #217 On March 17, 2022, at approximately 12:05 p.m., survey staff observed the smoke alarms in resident room #217 were tested by the DES-H and RDES-J. The smoke alarm inside the sleeping room failed to sound when the alarm outside of the sleeping room was tested and sounded. This finding was verified by the RDES-J as he stated that it probably was the speaker on the smoke alarm, and it needed to be replaced.	0 780		

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0 780	Continued From page 18 The RDES-J also added that they will go through all the smoke alarms at the facility and will look into replacing them to ensure proper functioning. On March 17, 2022, at approximately 3:15 p.m., LALD-F, DES-H, and RDES-J acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 810 SS=D	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 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	0 810		

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0 810	Continued From page 19 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 record review and interview, the licensee failed to provide the minimum required training of staff on fire safety and evacuation documentation. This has the potential to directly affect the safety of staff and all residents receiving care. 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 March 17, 2022, between the hours of 11:00 a.m. and 1:05 p.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-F, the director of environmental services (DES)-H, and the regional director of environmental services (RDES)-J. On March 17, 2022, at approximately 1:10 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review: -The policy documentation lacked the correct	0 810		

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0 810	Continued From page 20 minimum required content of frequency of employee training on the fire safety and evacuation plan at least twice per year, after new hire onboard training. This was evident in the facility's policy, Fire Safety/Evacuation Planning, dated July 15, 2021, page 2/7, stated the minimum of annual training after onboard employee training, rather than twice a year as required. Survey staff also asked for any records of employee training available. The LALD-F which stated that they have records of some recent employee training. Survey staff agreed to receive the additional training information via email by end of day on March 18, 2022. On March 17, 2022, at approximately 3:15 p.m., LALD-F, DES-H, and RDES-J acknowledged the above finding. Additional information was provided and received via email from the LALD-F on March 18, 2022, at 8:01 a.m., 1) Resident Council Meeting Minutes, dated, November 3, 2021, and 2) Supervisor Onboarding Checklist for a new employee on November 8, 2021 (2 pages). TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 910 SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if	0 910		

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0 910	Continued From page 21 applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked a written contract with the following required content: - license number. R1's Residency Agreement dated July 28, 2021, indicated the licensee held an Assisted Living with Dementia Care license, was licensed by the Minnesota Department of Health and included the AL (Assisted Living) license number as "PENDING." On March 16, 2022, at approximately 3:35 p.m., licensed assisted living director (LALD)-F stated the licensee had not received their license number when the contracts went to print, so the contracts went out to all residents to review and sign, without the license number. LALD-F stated the contract was never updated after receiving the license number, therefore, newly admitted	0 910		

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0 910	Continued From page 22 residents had been receiving the same contract without the license number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility'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 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:	0 970		

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0 970	Continued From page 23 During the entrance conference on March 15, 2022, at approximately 10:20 a.m., the surveyor requested a copy of the facility's assisted living with dementia care contract. The Residency Agreement contract included a clause on page 18, section 8, "Assumption of Risks, a. Personal Property of Resident" that indicated "Resident assumes primary responsibility for all risk for harm to or loss of any of Resident's personal property. Resident is encouraged, if so desired, to secure an Apartment or renter's insurance policy to protect against loss." Also included, "c. Other Losses or Damages," that indicated, "Resident acknowledges familiarity with the Apartment, the premises and services of the Community and is therefore willing to, and does, assume the risks associated with occupancy. Resident further acknowledges that neither the Owner nor any of its affiliates is an insurer of Resident's safety." On March 16, 2022, at approximately 3:35 p.m., licensed assisted living director (LALD)-F confirmed the assisted living contract required the above content and stated the same contract was utilized for all residents at the facility. LALD-F stated she had spoken to their attorney and felt the language met the regulation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01610 SS=E	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring	01610		

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01610	Continued From page 24 (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a Registered Nurse (RN) conducted an initial assessment using the uniform assessment tool for two of two residents (R3, R4) as required, with records reviewed. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings Include:	01610		

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01610	Continued From page 25 R3 R3 was admitted for services on February 24, 2022. R3's diagnoses included late onset Alzheimer's disease, irritable bowel syndrome, anxiety and malnutrition. R3's service plan dated February 24, 2022, indicated R3 received services which included medication administration, homemaking, laundry, unlimited escorts and vital monitoring. On March 16, 2022, at approximately 12:55 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R3's oral medications and rub a topical pain relief gel to her lower back. R3's record included an initial assessment titled, As Of Date, dated February 24, 2022. The assessment indicated R3 was independent with grooming, dressing, eating, bed mobility, transfers and toileting, and that she required assistance with medication administration. The assessment did not include all of the elements on the uniform assessment tool as required and was not authenticated with the name of the individual who completed it. R4 R4 was admitted for services on January 31, 2022. R4's diagnoses included sepsis (infection in the blood stream), urinary retention, weakness, congestive heart failure and cognitive communication deficit. R4's service plan, dated March 8, 2022, indicated R4 received services which included medication	01610		

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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
01610	Continued From page 26 administration, oxygen maintenance, shower assistance, vital monitoring, homemaking and laundry. On March 16, 2022, at approximately 1:47 p.m., the surveyor observed R4 sitting in her chair in her apartment. R4's record included an initial assessment titled, As Of Date, dated January 31, 2022. The assessment indicated R4 required help with bathing and medication administration, used an assistive device for walking, was independent with dressing, grooming, bed mobility and toileting. The assessment did not include all of the elements on the uniform assessment tool as required and was not authenticated with the name of the individual who completed it. On March 16, 2022, at 2:05 p.m., RN-A and RN-B stated they were transitioning to completing the assessments in their electronic medical records and were still learning the process. RN-A and RN-B confirmed the initial assessments did not include all required content of the uniform assessment tool and did not indicate who completed the assessments. On March 18, 2022, at approximately 9:35 a.m., RN-B indicated none of the initial assessments indicated who completed them and stated she had contacted their electronic records software provider to correct this. The licensee's MN [Minnesota] AL [Assisted Living] Nursing Assessment Policy, dated August 4, 2021, indicated a registered nurse would complete a comprehensive pre-admission assessment of the individual's physical and cognitive needs of prospective clients [residents]	01610		

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	30763	A. BUILDING: _____ B. WING _____	03/18/2022

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GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

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01610	Continued From page 27 and the assessment must include all the elements of the uniform assessment tool as required. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620		

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01620	Continued From page 28	01620		

Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services, for two of two residents (R3, R4) as required, and failed to ensure the RN completed a reassessment not to exceed 90 days for two of two residents (R1, R5) with records reviewed.

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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

14-DAY ASSESSMENTS

R3
R3 was admitted for services on February 24, 2022.

R3's diagnoses included late onset Alzheimer's disease, irritable bowel syndrome, anxiety and malnutrition.

R3's service plan dated February 24, 2022, indicated R3 received services which included medication administration, homemaking, laundry, unlimited escorts and vital monitoring.

On March 16, 2022, at approximately 12:55 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R3's oral medications and rub a topical pain relief gel to her lower back.

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01620	Continued From page 29 R3's record included document titled, Assessment As Of Date, dated March 10, 2022, intended to be the 14-day assessment. The assessment indicated R3 was independent with grooming, dressing, eating, bed mobility, transfers and toileting, and needed medication management and medication administration. Although the assessment was completed no more than 14 days after initiation of services, the assessment was completed by a licensed practical nurse, not an RN as required. R4 R4 was admitted for services on January 31, 2022. R4's diagnoses included sepsis (infection in the blood stream), urinary retention, weakness, congestive heart failure and cognitive communication deficit. R4's service plan, dated March 8, 2022, indicated R4 received services which included medication administration, oxygen maintenance, shower assistance, vital monitoring, homemaking and laundry. On March 16, 2022, at approximately 1:47 p.m., the surveyor observed R4 sitting in her chair in her apartment. R4's record included document titled, Assessment As Of Date, dated February 16, 2022, intended to be the 14-day assessment. The assessment indicated R4 required help with bathing and medication administration, used an assistive device for walking and was independent with dressing, grooming bed mobility and toileting. The assessment was completed 16 calendar	01620		

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01620	Continued From page 30 days after the initiation of services, instead of no more than 14 days after initiation of services, as required. 90-DAY ASSESSMENTS R1 began receiving services on June 25, 2021. R1's diagnoses included dementia, hypertension, lung cancer, depression and diabetes. R1's Service Plan, dated January 24, 2022, indicated R1 received services which included insulin administration and blood glucose checks, medication administration, shower assistance, unlimited escorts, laundry and vital monitoring. On March 16, 2022, at approximately 12:50 p.m., the surveyor knocked on R1's apartment door. R1 hollered that she was trying to take a nap and wanted to be left alone. R1's record contained a Comprehensive Clinical Review dated July 12, 2021, and document titled, Assessment As Of Date, dated January 27, 2022, intended to be a 90-day assessment. The 90-day reassessment was completed after 199 calendar days, rather than not to exceed 90 days, as required. R5 R5 began receiving services on May 7, 2018. R5's diagnoses included chronic obstructive pulmonary disease, chronic pain, hypertension and anemia. R5's Service Plan, dated February 25, 2022, indicated R5 received services including medication administration, oxygen maintenance,	01620		

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01620	Continued From page 31 shower assist, toileting assistance, transfer assistance, laundry and homemaking. On March 16, 2022, at approximately 1:28 p.m., the surveyor observed R5 in his apartment, watching television. R5's record contained a Comprehensive Clinical Review, dated May 27, 2021, and document titled, Assessment As Of Date, dated November 18, 2021, intended to be a 90-day assessment. The 90-day reassessment was complted after 175 calendar days. rather than not exceed 90 days, as required. On March 16, 2022, at approximately 11:53 a.m., RN-A stated during the pandemic and staffing crisis, the licensee's focus had been on admission assessments, so 14-day and 90-day reassessments did not get done. RN-A also stated the licensee was transitioning to completing the assessments on the electronic medical record and they were still learning that process. The licensee's MN [Minnesota] AL [Assisted Living] Nursing Assessment Policy, dated August 4, 2021, indicated the ongoing assessment would be completed periodically but no less than every 90 days and when there was a change in the resident's condition, and the assessment would include the components of the uniform assessment tool, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01640	Continued From page 32	01640		
01640 SS=D	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. (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 the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of five residents (R1) with records reviewed. 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	01640		

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01640	Continued From page 33 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's Service Plan, dated January 24, 2022, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided. On March 16, 2022, at approximately 12:50 p.m., the surveyor knocked on R1's apartment door. R1 hollered that she was trying to take a nap and wanted to be left alone. On March 16, 2022, at approximately 2:05 p.m., registered nurse (RN)-A stated R1's service plan had been revised on January 24, 2022, and confirmed it lacked a signature by the resident and the facility as required. RN-A stated she didn't know why the service plan had not been signed yet. The licensee's MN [Minnesota] AL [Assisted Living] Service Plan Policy, dated August 1, 2021, indicated service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services	01700		

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01700	Continued From page 34 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for five of five residents (R1, R2, R3, R4, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01700		

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01700	Continued From page 35 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: During the entrance conference on March 15, 2022, at approximately 10:20 a.m., licensed assisted living director (LALD)-F and RN-A stated the licensee provided medication management services to the licensee's residents. R1, R2, R3, R4 and R5's record lacked evidence the RN had conducted a medication assessment to include: - identification and review of all medications the resident is known to be taking. R1 R1 had a contract dated effective August 1, 2021. R1's Service Plan, dated January 24, 2022, indicated R1 received services which included insulin administration and blood glucose checks, medication administration, shower assistance, unlimited escorts, laundry and vital monitoring. R1's document titled, Assessment As of Date, dated January 27, 2022, intended as 90-day assessment, included a medication assessment; however, lacked the above required content. R1's prescriber orders dated July 2, 2021, included one antidepressant, one oral medication to lower blood sugar, one long-acting insulin pen, one thyroid medication and a sedative.	01700		

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01700	Continued From page 36 R1's February 2022, Med [medication] Sheets listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R2 R2 had a contract dated effective August 1, 2021. R2's Service Plan, dated October 29, 2021, indicated R2 received services which included assistance with bed mobility, incontinence care, meal assistance, medication management, shower assistance and homemaking. R2's document titled, Assessment As of Date, dated February 7, 2022, intended as 90-day assessment, included a medication assessment; however, lacked the above content. R2's prescriber orders dated February 7, 2022, included four supplements, one medication to prevent bone loss, one medication for bone health and one medication to treat muscle spasms. R2's February 2022 Med [medication] Sheets listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R3 R3 had a contract dated effective February 21, 2022. R3's Service Plan dated February 24, 2022, indicated R3 received services which included medication administration, homemaking, laundry, unlimited escorts and vital monitoring.	01700		

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01700	Continued From page 37 R3's document titled, Assessment As of Date, dated March 10, 2022, intended as 14-day assessment, included a medication assessment; however, lacked the above content. R3's prescriber orders dated March 3, 2022, included three supplements, one antianxiety, two pain medications, and one medication to treat diarrhea. R3's February 2022 and March 2022 Med [medication] Sheets listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R4 R4 had a contract dated effective January 13, 2022. R4's service plan, dated March 8, 2022, indicated R4 received services which included medication administration, oxygen maintenance, shower assistance, vital monitoring, homemaking and laundry. R4's document titled, Assessment As of Date, dated February 16, 2022, intended as 14-day assessment, included a medication assessment; however, lacked the above content. R4's prescriber orders dated February 3, 2022, included three supplements, one medication to treat edema, one thyroid medication, one heart medications and one medication to treat constipation. R4's February 2022 and March 2022 Med [medication] Sheets listed medications as prescribed, times to be administered, and staff	01700		

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01700	Continued From page 38 initials on each date to indicate the medications had been given. R5 R5 had a contract dated July 30, 2021. R5's Service Plan, dated February 25, 2022, indicated R5 received services including medication administration, oxygen maintenance, shower assist, toileting assistance, transfer assitance, laundry and homemaking. R5's document titled, Assessment As of Date, dated November 18, 2021, intended as 90-day assessment, included a medication assessment; however, lacked the above content. R5's prescriber orders dated May 5, 2021, included one supplement, one medication to treat edema, one heart medication, one pain medication and one antacid. R5's February 2022 and March 2022 Med [medication] Sheets listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. On March 16, 2022, at approximately 2:05 p.m., RN-A and RN-B confirmed the assessments lacked the above required content and stated the same form was utilized for all residents. The licensee's MN (Minnesota) AL (Assisted Living) Medication Management Policy, dated August 5, 2021, lacked direction to complete a medication assessment to include the required content. No further information was provided.	01700		

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01700	Continued From page 39 TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
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 observation, document review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify both the hazard vulnerabilities and the mitigations on and around the property. The hazards identified in the HVA plan must be mitigated to protect the memory care residents from harm. This has the potential to directly affect all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	02040		

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GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

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02040	Continued From page 40 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On March 17, 2022, between the hours of 11:00 a.m. and 1:05 p.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-F, the director of environmental services(DES)-H, and the regional director of environmental services (RDES)-J. On March 17, 2022, at approximately 1:10 pm, survey staff received the HVA documentation for review: - The facility HVA plan lacked mitigations documentation including safety measures and/or training provided to the hazard vulnerability and safety risk assessment identified on the facility's interior and around the exterior of the property to protect all memory care residents from potential harm. On March 17, 2022, at approximately 3:15 p.m., the licensed assisted living director-F, the DES-H, and the RDES-J acknowledged the above findings during the exit interview as they asked for more information on mitigation details for their documentation. Survey staff explained that all potential safety risks or harm including the facility's HVA plan, Appendix B, Table "Interior Hazard Assessment" must also include mitigations to protect memory care residents from harm. Staff also suggested the facility safety employee perform a walk-through of their memory care unit for a more comprehensive list of hazard assessments to establish mitigations to protect the residents from potential harm that	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30763	A. BUILDING: _____ B. WING _____	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

(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
02040	Continued From page 41 includes elopement risks from secured windows being comprised, deactivation of power doors due to loss of power, updating policies regarding household appliances such as coffee machines or tea kettles inside the resident rooms provided by their family, and the risks of the misuse of unsecured portable fire extinguishers or architectural accessories throughout the unit. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30763	A. BUILDING: _____ B. WING _____	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

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02110	Continued From page 42 how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents with dementia care, staff 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 is 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 lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30763	A. BUILDING: _____ B. WING _____	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

(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
02110	Continued From page 43 resident's legal and designated representative. The licensee held an assisted living with dementia care license through July 31, 2022, and was licensed for a bed capacity of 88 residents. On March 16, 2022, at 3:35 p.m., the licensed assisted living director (LALD)-F confirmed the inclusive list of dementia care policies and procedures had not been provided to each resident and/or representative. The licensee lacked a policy regarding the procedure for how the dementia care policies would be distributed to each resident and/or representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30763	A. BUILDING: _____ B. WING _____	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

(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
02170	Continued From page 44 activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions, and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R1, R3) who resided in the Arbor secured memory care unit, with record review. 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).	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30763	A. BUILDING: _____ B. WING _____	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

(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
02170	Continued From page 45 The findings include: The facility had an assisted living with dementia care license, effective August 1, 2021. R1 R1's diagnoses included dementia, hypertension, lung cancer, depression and diabetes. R1's document titled, Assessment As Of Date, dated January 27, 2022, indicated R1 had been active her whole life, and enjoyed gardening, walking, watching television and pets. The assessment indicated R1 needed daily reminders to attend activities and needed frequent redirection. The assessment lacked evaluation of the following: -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, R1's record lacked an individualized activity plan based on the activity evaluation that reflected R1's activity preferences and needs. R3 R3's diagnoses included late onset Alzheimer's disease, irritable bowel syndrome, anxiety and malnutrition. R3's document titled, Assessment As of Date, dated March 10, 2022, indicated what R3's former career had entailed, and R3 needed reminders and encouragement to participate in activities. The assessment lacked evaluation of the following:	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30763	A. BUILDING: _____ B. WING _____	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACEPOINTE CROSSING	1545 RIVERHILLS PARKWAY NW CAMBRIDGE, MN 55008

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02170	Continued From page 46 -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. In addition, R3's record lacked an individualized activity plan based on the activity evaluation that reflected R3's activity preferences and needs. On March 16, 2022, at approximately 3:00 p.m., licensed assisted living director (LALD)-F stated the licensee was in transition in their life enrichment program and confirmed the residents lacked an evaluation for activities and an individualized activity plan, as required. The licensee's Life Enrichment Policy, dated August 1, 2021, indicated the life enrichment program was designed to serve the total person through all wellness dimensions: spiritual, social, physical, intellectual, environmental, emotional and vocational. The policy directed getting to know the residents' history, preferences, dreams and hopes by completing the resident assessment, welcome days, care conferences, and everyday interactions. The policy lacked direction to complete an individualized activity plan based on the activity evaluation that reflected the residents' activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/15/22*
Time: 11:30:00
Report: 1025221050

Food and Beverage Establishment Inspection Report

Location:
Gracepointe Crossing
1545 Riverhills Parkway Nw
Cambridge, MN55008
Isanti County, 30

Establishment Info:
ID #: 0038374
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636891474
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

Maintain temperature of 41 deg or below if TCS foods to be maintained in the community room snack refrigerator. Adjust temperature, check using available temperature measuring device.

Comply By: 03/15/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Provide a cooler in the community room area for snacks (e.g. sandwiches) which meets the above requirement, if it will be used to store TCS foods. Residential refrigerators do not meet the above requirement.

Comply By: 04/12/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Hot Water: = at 163 Degrees Fahrenheit
Location: 164 W, 187 R, 163 C, 20 PSI
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: SV1 dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Corned beef
Temperature: 38 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Soup
Temperature: 145 Degrees Fahrenheit - Location: Hot holding expo
Violation Issued: No

Process/Item: Soup
Temperature: 155 Degrees Fahrenheit - Location: Hot holding expo
Violation Issued: No

Process/Item: Eggs
Temperature: 38 Degrees Fahrenheit - Location: Undercounter prep cooler L
Violation Issued: No

Process/Item: Diced tomato
Temperature: 40 Degrees Fahrenheit - Location: Prep cooler R
Violation Issued: No

Process/Item: Cooked chicken
Temperature: 40 Degrees Fahrenheit - Location: Drawer cooler grill
Violation Issued: No

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Expo cooler
Violation Issued: No

Process/Item: Chicken, cooked
Temperature: 38 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Ambient
Temperature: 43 Degrees Fahrenheit - Location: Community area snack refrigerator
Violation Issued: Yes

Process/Item: Ambient
Temperature: 40 Degrees Fahrenheit - Location: Bistro display cooler
Violation Issued: No

Process/Item: Tomato
Temperature: 42 Degrees Fahrenheit - Location: SV1 cooling from ambient upright
Violation Issued: No

Process/Item: Ambient
Temperature: 40 Degrees Fahrenheit - Location: SV1 upright cooler
Violation Issued: No

Type: Full
Date: *03/15/22*
Time: 11:30:00
Report: 1025221050
Gracepointe Crossing

Food and Beverage Establishment Inspection Report

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

Discussed food labeling for items: sold in bistro (POS discussion); to be provided as a snack in the community area (full label information on these items, fact sheet provided with report); food source, storage; employee illness reporting, recording, and exclusion; cooling processes; freezer storage and log; equipment and testing; pasteurized eggs used onl, no raw or undercooked animal products offered; use of bleach for cleaning and soaking dish curtains (following label directions for water volume for 50-100 PPM).

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 1025221050 of 03/15/22.

Certified Food Protection Manager: Michelle Muehlberg

Certification Number: FM99470 Expires: 06/25/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
Buffy

Signed: _____
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025221050

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date 03/15/22
No. of Repeat RF/PHI Categories Out	0	Time In 11:30:00
Legal Authority MN Rules Chapter 4626		Time Out

Gracepointe Crossing	Address: 1545 Riverhills Parkway Nw	City/State: Cambridge, MN	Zip Code: 55008	Telephone: 7636891474
License/Permit #: 0038374	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

Compliance Status		COS	R
Supervision			
1	IN OUT — PIC knowledgeable; duties & oversight		
2	IN OUT N/A — Certified food protection manager, duties		
Employee Health			
3	IN OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT — Proper use of reporting, restriction & exclusion		
5	IN OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6	IN OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8	IN OUT N/O — Hands clean & properly washed		
9	IN OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT — Adequate handwashing sinks supplied/accessible		
Approved Source			
11	IN OUT — Food obtained from approved source		
12	IN OUT N/A N/O — Food received at proper temperature		
13	IN OUT — Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15	IN OUT N/A N/O — Food separated and protected		
16	IN OUT N/A — Food contact surfaces: cleaned & sanitized		
17	IN OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O — Proper cooking time & temperature		
19	IN OUT N/A N/O — Proper reheating procedures for hot holding		
20	IN OUT N/A N/O — Proper cooling time & temperature		
21	IN OUT N/A N/O — Proper hot holding temperatures		
22	IN OUT N/A — Proper cold holding temperatures		
23	IN OUT N/A N/O — Proper date marking & disposition		
24	IN OUT N/A N/O — Time as a public health control: procedures & records		
Consumer Advisory			
25	IN OUT N/A — Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26	IN OUT N/A — Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27	IN OUT N/A — Food additives: approved & properly used		
28	IN OUT — Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29	IN OUT N/A — Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance. Mark "X" in appropriate box for COS and/or R. **COS=** corrected on-site during inspection **R=** repeat violation

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 03/18/22

Inspector (Signature) Cory Kline