Electronically Delivered

June 8, 2022

Administrator
Aspen Grove Alternative Senior
511 Iron Drive
Chisholm, MN 55719

RE: Project Number SL37901015

Dear Administrator:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial on May 25, 2022, for the purpose 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.

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 Home Care 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 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 residents/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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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,

Jessica Sellner, RN, Supervisor
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: jessica.sellner@state.mn.us
Phone: 320-223-7370
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
	37901	A. BUILDING: _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ALTERNATIVE SENIOR	511 IRON DRIVE CHISHOLM, MN 55719

(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****** ASSSITED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL37901015 On, May 23, 2022 through May 25, 2022, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. At the time of the survey, there were 20 residents receiving services under the Assisted Living 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means to request staff assistance for two of two residents, R2 and R5, reviewed. In addtition, the licensee did not have a system in place for any of the residents who reside at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all 20 residents at the facility. 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 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	0 460		

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0 460	Continued From page 2 portion or all of the residents). The findings include: R2 was admitted to the facility on August 19, 2021, with diagnoses including dementia and osteoarthritis. R2's admission assessment indicated she was at a risk for falls and required a walker and staff assistance with mobility. R2 was dependant on staff for activities of daily living including dressing, bathing, grooming, toileting, and incontinence care. R2's mental status questionnaire (MSQ) assessment August 19, 2021, indicated she was severely cognitively impaired. R2's care plan August 19, 2021, indicated the resident had dementia but could understand simple instruction verbally and non verbal communication. The care plan indicated R2 was not able to summon for staff assistance or call for help using a telephone and was unable to use a summoning device to request assistance. The care plan indicated staff would anticipate the residents needs and conduct safety checks. R5 was admitted to the facility on March 27, 2013, with diagnoses including alcohol induced dementia and bipolar disorder. R5's service plan dated September 5, 2021, indicated the resident required staff assistance with transfers and mobility. R5's care plan dated May 18, 2021, indicated the resident was cognitively impaired and required staff to monitor and provide safety. The care plan	0 460		

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0 460	Continued From page 3 indicated R5 had infrequent falls and instructed staff to provide assistance with transfers and ambulation, and report any falls immediately. R5 was forgetful but could understand simple instruction verbally and non verbal communication. R5 was not able to summon for assistance or call for help using a call light or telephone, and indicated staff were to anticipate R5's needs and complete safety checks. On May 23, 2022, approximately 1:00 p.m. Registered Nurse (RN)-A stated there was no call system in place in the facility and stated the residents "prefer to yell out or walk and find someone". RN-A stated all residents were independent with ambulation. RN-A stated she was not aware of a policy for the resident's preference for no call light addressed on admission and indicated the residents would be unable to summon for assist and due to dementia, and staff would anticipate their needs, and complete safety checks. On May 24, 2022, at 11:24 a.m. unlicensed personnel (ULP)-D stated there were no call lights or a call system available for residents. ULP-D stated staff had all the resident's who need assistance in the main common areas during the day and the more independent residents could be in their room. ULP-D stated if the residents were in their room they had to round on them every hour or so to check on them, and indicated rounding was not documented anywhere. On May 24, 2022, at 1:58 p.m. RN-A stated she had added to the resident MSQ assessment form done on admission, and updated the form to include preference for use of a summoning device. RN-A verified residents currently did not	0 460		

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0 460	Continued From page 4 have documentation of their ability to use or not use a call light and/or the resident's call light preference documented in their chart, and there was no system currently in place for residents to summon assistance 24 hours a day. The facility's Summoning Device Policy dated August 31, 2021 indicated the facility would assess each resident for the ability and desire to use a summoning device by using person-centered practice to allow each resident to choose whether or not they desire a summoning device. Residents unable to summon assistance or call for help will be monitored and staff will anticipate the needs and provide support and assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 460		
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	0 480		

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0 480	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all nine residents. 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 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated May 26, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 680		

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0 680	Continued From page 6 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 interview and record review, the licensee failed to develop a written emergency disaster plan with all the required content. 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) 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:	0 680		

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0 680	Continued From page 7 On May 23, 2022, at 10:30 a.m., survey staff requested the facility's emergency preparedness plan. On May 23, 2022, at 11:00 a.m., during a facility tour, the licensee neglected to post information regarding an emergency preparedness plan in the common areas of the facility. On May 24, 2022, at 9:30 a.m., the surveyor reviewed the Emergency Preparedness Management Plan and policies, dated April 12, 2022. The Emergency Preparedness Management Plan and related emergency preparedness policies were incomplete and did not meet requirements. The plan did not include: - Procedure for tracking of staff and patients - Policy and procedure for sheltering in place - Policy and procedure for medical documents during an emergency - Policy and procedure for volunteers during an emergency - Arrangement agreement with other facilities - Development of a communication plan that includes names and contact information, emergency officials contact information, primary and alternate means of communication, methods for sharing information, methods for sharing information on occupancy and needs, and method for sharing information for the emergency plan with residents and family - Emergency preparedness training and documentation of training No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 680		

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0 810	Continued From page 8	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the required plans for fire safety	0 810		

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0 810	Continued From page 9 and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 25, 2022, between 10:15 a.m. and 10:50 a.m., survey staff toured the facility with the owner (O)-E and the licensed assisted living director (LALD)-C. During the facility tour, it was observed that the evacuation maps posted in the facility did not identify the location and number of resident sleeping rooms. In an interview with the O-E and LALD-C during the tour, they confirmed that evacuation maps failed to include the location and number of resident sleeping rooms. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission,	03000		

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03000	Continued From page 10 unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by:	03000		

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03000	Continued From page 11 Based on interview and record review, the licensee failed to report potential maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) and complete an investigation of the incident for one of one resident (R5), who had a unwitnessed fall resulting in injury. . 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) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings Include: R5 was admitted to the facility on March 27, 2013, with diagnoses including alcohol induced dementia and bipolar disorder. R5's service plan dated September 5, 2021, indicated the resident required hands on assistance with transfers and mobility. R5's care plan dated May 18, 2021, indicated the resident was cognitively impaired and required staff to monitor and provide safety. The care plan indicated R5 had infrequent falls and instructed staff to provide assistance with transfers and ambulation, and report any falls immediately. A facility incident report dated February 23, 2022, at 10:30 a.m. completed by registered nurse (RN)-C indicated R5 was found in an empty room on the floor and had facial bruising and complained of elbow pain and was sent to the emergency room. The incident report lacked further investigation into the injury including	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37901	A. BUILDING: _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASPEN GROVE ALTERNATIVE SENIOR	511 IRON DRIVE CHISHOLM, MN 55719

(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
03000	Continued From page 12 information on when the resident was last seen, toileted, and who found the resident. The facility had no further documenting of the incident. A progress note dated February 23, 2022, un-timed, indicated R5 was found on a floor in a vacant room, and stated she was "going for a walk." R5 had right side facial bruising around and along side her eye and also had complaint of elbow pain. R5 was sent to urgent care for evaluation. R5's clinic after visit summary dated February 23, 2022, indicated the resident had a unwitnessed fall, and the imaging result identified a fracture of the right elbow. On May 24, 2022, at 3:15 p.m. when interviewed RN-C and RN-A verified no report had been filed. The facility policy and procedure titled Vulnerable Adult Maltreatment - Prevention and Reporting, dated August 30, 2021, defined maltreatment as abuse, neglect and exploitation/theft. The policy indicated staff would report suspected maltreatment of a resident or if a resident had a significant injury that could not be reasonably explained no later than 24 hours after being made aware of the incident. The policy failed to indicate the facility would investigate potential suspected maltreatment of a vulnerable adult. Time Period for Correction: Fourteen (14) days.	03000		
03030 SS=D	626.557 Subd. (4,a) Internal reporting of maltreatment (a) Each facility shall establish and enforce an ongoing written procedure in compliance with	03030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37901	A. BUILDING: _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03030	Continued From page 13	03030		

applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section.
(b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter. (c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally.
(d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to immediately report potential maltreatment and complete an investigation for two of two residents (R3 and R5), with incidents reviewed.

This practice resulted in a level two violation (a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37901	A. BUILDING: _____ B. WING _____	05/25/2022

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03030	Continued From page 14	03030		

violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

Findings Include:

R3 was admitted to the facility on May 2, 2022, with a diagnosis of alcohol abuse, dementia, and hypertension.

R3's Individual Abuse Prevention Plan plan dated May 2, 2022 indicated he required monitoring due to dementia. R3 was an elopement risk due to dementia and staff were directed to monitor R3's whereabouts, monitor for statements about leaving, and provide a secure environment while indoors and outdoors.

R3's facility progress note dated May 2, 2022 indicated R3 eloped from the facility on May 2, 2022. Staff contacted law enforcement for assistance and R3 was found approximately 0.2 miles away from the facility.

R3's medical record lacked information regarding the incident including who found the resident, details including time and documentation of the incident being reported internally, and actions taken by the facility to keep the resident safe. The resident record lacked any evidence an investigation was completed and no incident report was completed. In addition, the incident was not reported to MAARC.

R5 was admitted to the facility on March 27, 2013, with diagnoses including alcohol induced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37901	A. BUILDING: _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03030	Continued From page 15 dementia and bipolar disorder. R5's service plan dated September 5, 2021, indicated the resident required hands on assistance with transfers and mobility. R5's care plan dated May 18, 2021, indicated the resident had cognitive impairment and required staff to monitor and provide safety. The care plan indicated R5 had infrequent falls and instructed staff to provide assistance with transfers and ambulation, and report any falls immediately. A facility incident report dated February 23, 2022, at 10:30 a.m. completed by registered nurse (RN)-C indicated R5 was found in an empty room on the floor and had facial bruising and complaints of elbow pain. R5 was sent to the emergency room. R5's progress note dated February 23, 2022, indicated the resident was found on a floor in a vacant room, and stated she was "going for a walk." R5 had right side facial bruising around and along side her eye, had complaints of elbow pain, and was sent to urgent care for evaluation. R5's clinic after visit summary dated February 23, 2022, indicated the resident had a unwitnessed fall, and the imaging result identified a fracture of the right elbow. A review of R5's medical record lacked information regarding the incident including who found the resident, and details including time and documentation of the incident being reported internally, and actions taken by the facility to keep the resident safe. The resident record lacked any evidence an investigation was completed. In addition, the incident was not reported to	03030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37901	A. BUILDING: _____ B. WING _____	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03030	Continued From page 16 MAARC. On May 24, 2022, at 3:15 when interviewed RN-C and RN-A stated the incident with R3 and R5 were not reported to MAARC. The facility policy titled ALDC Wandering and Elopement dated August 30, 2022, indicated the facility system to minimize elopement include a secured environment. The facility policy titled Missing Resident dated August 30, 2022, indicated an incident report will be completed to include all information concerning the resident disappearance including time of first alert, procedure and staff involved, time 911 was notified, time resident is found, and facility building needs addressed. The facility policy and procedure titled Vulnerable Adult Maltreatment - Prevention and Reporting, dated August 30, 2021, defined maltreatment as abuse, neglect and exploitation/theft. The policy indicated staff would report suspected maltreatment of a resident or if a resident had a significant injury that could not be reasonably explained no later than 24 hours after being made aware of the incident. The policy failed to indicate the facility would investigate potential suspected maltreatment of a vulnerable adult. Time Period for Correction: Fourteen (14) days.	03030		

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

Type: Full
Date: *05/25/22*
Time: 10:30:00
Report: 1006221068

Food and Beverage Establishment Inspection Report

Location:
Aspen Grove Alternative Senior
511 Iron Drive
Chisholm, MN55719
St. Louis County, 69

Establishment Info:
ID #: 0040099
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114A ** Priority 1 **

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

SEE COMMENTS.

Comply By: 06/01/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

OWNER CURRENTLY HAS AN EMPLOYEE SIGNED UP TO TAKE THE COURSE AND TEST. ONCE THE EMPLOYEE TAKES THE COURSE AND PASSES THE TEST SEND IN THE STATE APPLICATION AND FEE TO RECEIVE THE STATE CFPM CERTIFICATE.

Comply By: 07/01/22

2-100 Supervision

2-102.12DMN

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

ONCE THE STATE CERTIFICATE IS RECEIVED POST THE CERTIFICATE IN THE ESTABLISHMENT.

Comply By: 07/15/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12G

MN Rule 4626.0275G Store the bulk food dispensing utensil in the food with the handle extending out of the food, or in a protective enclosure attached or adjacent to the enclosure with the utensil on a tether of easily cleanable material which is short enough to prevent the utensil from making contact with the floor.

MEASURING CUP HANDLE WAS IN THE SUGAR IN THE BULK SUGAR CONTAINER. DISCUSSED EITHER NOT KEEPING SCOOPS IN THE CONTAINERS OR IF SCOOPS ARE KEPT IN THEM THE HANDLE MUST BE STORED UP AND OUT OF THE FOOD. SCOOP WAS REMOVED.

Corrected on Site

6-200 Physical Facility Design and Construction

6-201.14A

MN Rule 4626.1350A Remove carpeting or similar material from the following unapproved areas: food preparation areas; walk-in refrigerators or freezers; warewashing areas; toilet room areas where handwashing sinks, toilets and urinals are located; refuse storage areas; wait stations; dressing rooms; locker rooms; janitorial areas; within 3 feet around permanently installed bars and salad bars, other food service equipment, and food storage rooms; or other areas where the floor is subject to moisture, flushing, or spray cleaning methods.

THERE WAS A CARPET RUG TAPED ON THE FLOOR IN THE STORAGE AREA. DISCUSSED THAT THESE ARE ABSORBENT AND NOT EASILY CLEANABLE. MATS CAN BE USED AS LONG AS THEY ARE NON-ABSORBENT, DURABLE, AND EASILY CLEANABLE.

Comply By: 06/15/22

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: GRAPE JUICE
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: MELON
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: CHERRY JUBILEE
Violation Issued: No

Type: Full
Date: *05/25/22*
Time: 10:30:00
Report: 1006221068
Aspen Grove Alternative Senior

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	4

COMMENTS:

INSPECTION ACCOMPANIED BY PUBLIC HEALTH SANITARIAN, BEN KUBES, AND OWNER, CHUCK GARGANO.

ESTABLISHMENT HAS QUATERNARY AMMONIA HOOKED UP TO THE DISH MACHINE. IT IS REGISTERING 400 PPM, BUT QUAT TYPICALLY ISN'T USED IN DISH MACHINES DUE TO CONTACT TIME REQUIRED TO SANITIZE. DISCUSSED CONTACTING SULLIVAN'S TO CONFIRM THEY HAVE THE PROPER SANITIZER HOOKED UP. THEY WILL LIKELY NEED TO USE A CHLORINE BASED SANITIZER INSTEAD. DISCUSSED IF/WHEN CHANGING OVER FROM QUAT TO CHLORINE MAKE SURE TO COMPLETELY CLEAN THE LINES AND RUN FRESH WATER THROUGH A FEW TIMES SO AS NOT TO MIX THE TWO CHEMICALS.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH HEPATITIS A., E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS OR IF THERE ARE ANY FOODBORNE ILLNESS COMPLAINTS.

DISCUSSED THE ESTABLISHMENT'S HAND WASHING AND BARE HAND CONTACT POLICY.

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 1006221068 of 05/25/22.

Certified Food Protection Manager: In Progress

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Charles and Brenda Gargano
Owners

Signed: _____
Callie Harrison

218-302-6173
callie.harrison@state.mn.us

Report #: 1006221068

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	2	Date	05/25/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Aspen Grove Alternative Senior	511 Iron Drive	Chisholm, MN	55719	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0040099		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
Proper Use of Utensils				
43	X	In-use utensils: properly stored	X	
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	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:** 05/26/22

Inspector (Signature) Callie Hanson