DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 28, 2021

Administrator
Evygabs Healthcare Systems, LLC
20604 Enfield Avenue North
Forest Lake, MN 55025

RE: Project Number(s) SL36395015-1

Dear Administrator:

On December 14, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 7, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

Electronically Delivered

October 25, 2021

Administrator
Evygabs Healthcare Systems LLC
20604 Enfield Avenue North
Forest Lake, MN 55025

RE: Project Number(s) SL36395015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 7, 2021, 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 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), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

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

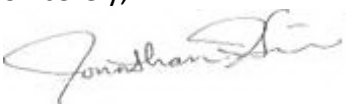
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
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P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36395	A. BUILDING: _____ B. WING _____	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVYGABS HEALTHCARE SYSTEMS LLC	20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are 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: SL36395015 On October 6, 2021 through October 7, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were four (4) residents receiving services under the provider's Assisted Living 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 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 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was developed and posted in a central location, potentially affecting the licensee's four current residents, staff and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 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 a posted daily staffing schedule developed by the clinical nurse supervisor to include: - Direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked. - The direct-care staff members resident assignments or work location. - Be posted after redacting direct-care staff members resident assignments, at the beginning of each work shift in a central location in each building. On October 6, 2021, at 10:00 a.m., the surveyor conducted a tour of the licensee's building. A staffing schedule was not posted in a central location. On October 7, 2021, at 9:10 a.m., the administrator confirmed a staffing schedule was not posted in a central location. The licensee's Staffing & Scheduling policy dated August 10, 2021, indicated a 24-hour daily staffing schedule would be posted at the beginning of each work shift in a central location, accessible to staff, residents, volunteers and the public. No further information was provided.	0 470		

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0 470	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
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 had the potential to affect all four residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 480		

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0 480	Continued From page 4 has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated, October 6, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and	0 490		

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0 490	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities. This had the potential to affect all four residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 a program of daily social and recreational activities. Resident (R)-1's record was reviewed. R1 moved into the facility on March 8, 2021, due to diagnoses that included major depression, anxiety, and post-traumatic stress disorder. R1's service plan dated August 19, 2021, indicated R1 received services from the assisted living provider that included housekeeping, laundry, medication administration, wound care, and supervision of wound care by a registered nurse. R1's assessment dated September 19, 2021, indicated that when given the opportunity, R1 enjoyed cross stitch, coloring, board games, and crafts. During a tour of the facility on October 6, 2021, at 9:45 a.m. the investigators observed an activity	0 490		

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0 490	Continued From page 6 calendar dated September 2021 hanging on the staff office wall. There was no activity calendar for October 2021. On October 6, 2021, at 10:45 a.m., R1 stated that there were few activities at the facility and she never really got out, did not have much to do, and was often bored. R1 stated she had too much down time. On October 6 and 7, 2021, observations throughout the morning and afternoon revealed the licensee did not offer any recreational or social activities. The Activity Programming policy dated August 10, 2021, indicated the facility provided a wide range of activities and social recreation for residents. The policy indicated a monthly calendar would be created and available to all residents which may include the following: social events, religions events, exercise and wellness events, creative opportunities, intellectual opportunities, cultural events, and volunteer opportunities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.	0 510		

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0 510	Continued From page 7 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observations, interview and record review, the facility failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19 per the Centers for Disease Control (CDC) and Minnesota Department of Health (MDH) guidelines. This had the potential to affect all 4 residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 failed to properly screen visitors for COVID-19 by not assessing for symptoms of illness. On October 6, 2021, at 9:00 a.m., the state surveyors entered the facility. There were no COVID-19 screening signs at the facility's main entrance. The administrator (A)-A admitted the state surveyors into the facility. A-A did not take the state surveyor's temperature and did not ask the surveyors any symptom assessment questions. The state surveyors entered the licensee's premises, and licensee staff did not	0 510		

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0 510	Continued From page 8 screen for COVID-19 symptoms. On October 6, 2021, at 10:15 a.m., the state sanitarian entered the facility, and A-A did not screen for COVID-19 symptoms and did not take her temperature. MDH guideline titled, COVID-19 Toolkit, Information for Long-Term Care Facilities, dated March 8, 2021, indicated as of March 8, 2021, visitors must be screened for fever and symptoms of illness related to COVID-19. Screening included assessing for a fever, (measured temperature higher than 100 degrees Fahrenheit), or subjective fever (chills, feeling feverish), and asking about new symptoms of illness (measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste and smell). On October 7, 2021, at 9:10 a.m., A-A confirmed he had not taken visitors temperatures or screened visitors for symptoms of COVID-19. The licensee's Policy and Procedure on COVID-19 Preparation for Our Facility policy dated June, 2020, indicated all visitors would be restricted except for certain circumstances. The policy lacked information related to visitor screening for COVID-19 symptoms. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 9 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 the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all four residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked a posting in a common area of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there	0 550		

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0 550	Continued From page 10 was no evidence of posting in the common area of 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. On October 6, 2021, during a facility tour at approximately 10:45 a.m., an observation of the facility's common areas noted the lack of the required posting of the grievance procedure and Ombudsman contact information. On October 7, 2021, at 9:00 a.m., the administrator verified the required information was not posted in the common areas of the facility. The licensee's Complaint/Grievance Posting policy dated August 10, 2021, indicated the licensee would post in a conspicuous place, information about their complaint/grievance procedure, including the name, telephone number and email contact information for the individuals who are responsible for handling resident complaint/grievances. The policy also indicated the posting would have the contact information for the office of ombudsman for long term care and the ombudsman for mental health and developmental disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant	0 580		

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	36395	A. BUILDING: _____ B. WING _____	10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVYGABS HEALTHCARE SYSTEMS LLC	20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025

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0 580	Continued From page 11 to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity. This had the potential to affect all four residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 7, 2021, at 9:15 a.m., the administrator confirmed there was no quality management documentation. The licensee's Quality Management Project policy dated August 10, 2021, indicated the licensee would have at least one documented quality management project in place at all times, and	0 580		

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0 580	Continued From page 12 retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report to the Minnesota Adult Abuse Reporting Agency (MAARC) an incident of self neglect for one of one resident (R2) with discharged record 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 620		

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0 620	Continued From page 13 R2 was discharged to homelessness, leaving per R2's preference, without needed medications, and the licensee failed to report this incident of self-neglect. R2's Resident Notes dated September 19 and 20, 2021, completed by the administrator (A)-A and registered nurse (RN)-E indicated R2 was admitted to licensee facility on September 19, 2021, with diagnoses of schizophrenia and diabetes. A-A was requested by R2's girlfriend and case manager to pick up R2. R2 was found by A-A sleeping outside with no shirt or shoes. R2 agreed to come to licensee's facility. R2 was offered housing on September 19, 2021. An assisted living contract was never executed and a nursing assessment was not conducted due to R2's refusal and non-compliance. R2 was non-compliant with medication administration with the exception of one injection of Risperdal (anti-psychotic) administered by the licensee's registered nurse (RN)-E. R2's Discharge Summary dated October 4, 2021, completed by RN-E, indicated R2 was discharged on September 20, 2021, to return to live on the street. The Discharge Summary listed R2's behavior as physically and verbally aggressive. The discharge summary included: Concerned about decision to care for self and make good decisions. On October 7, 2021, at 9:10 a.m., the A-A confirmed he did not call or report this incident of self neglect into MAARC, but did indicate he had notified R2's case manager that R2 left to go back to homelessness. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated August 10, 2021, indicated of the licensee's staff were mandated reporters, and the facility would support protection and safety through the states system for reporting suspected vulnerable adult	0 620		

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0 620	Continued From page 14 maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c 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 post the required content in common areas to include: Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility and posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all four residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 15 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked the following: - posting of 911 emergency number in common areas and near telephones provided by the assisted living facility - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557 On October 6, 2021, at 10:00 a.m., an observation made of the facility main entry area and common areas noted a lack of the required posted information. On October 7, 2021, at 9:10 a.m., the administrator confirmed the required content noted above had not been posted as required. The licensee's Complaint /Grievance Posting policy dated, August 10, 2021, indicated the licensee would post information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The licensee lacked a policy regarding posting of 911 emergency numbers in common area and near telephones. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		

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0 680	Continued From page 16	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 plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all 4 residents receiving services under the assisted living license, staff,	0 680		

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0 680	Continued From page 17 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: On October 6, 2021, at 10:00 a.m., the surveyors conducted a tour of licensee's building. An emergency preparedness plan was not posted in a central location. During the entrance conference on October 6, 2021, at approximately 10:45 a.m., a request was made to view the licensee's emergency preparedness plan. The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment. -description of the population served by licensee. -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations. -subsistence needs for staff and residents during emergency situation. -procedure for tracking staff and residents. -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including	0 680		

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0 680	Continued From page 18 documentation of training provided); -annual EP testing requirements. On October 7, 2021, at 9:10 a.m., the administrator confirmed the current emergency preparedness plan lacked all required content and verified the plan was not posted prominently. The licensee's Emergency Preparedness policy dated August 20, 2021, indicated the facility must develop an emergency and disaster plan that is in alignment with facility requirements to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	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	0 780		

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0 780	Continued From page 19 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 ensure a smoke alarm was installed in one of five bedrooms. This had the potential to affect early detection for 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, 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 October 7, 2021, at approximately 10:40 a.m., it was observed bedroom #5 on the main floor did not have a smoke alarm installed as required. As this bedroom is licensed as bedroom #5, the licensee must provide and maintain a smoke alarm in this bedroom including interconnection of this alarm to the alarm system so the actuation of this alarm causes all alarms to actuate in the dwelling unit. On October 7, 2021, at approximately 10:40 a.m., the Administrator confirmed the missing alarm as he explained that this bedroom is currently used as an office. He also asked if they can install the new smoke alarm and connect to the system that	0 780		

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0 780	Continued From page 20 is currently located outside the bedroom. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide and maintain fire extinguishers in accordance with the State Fire Code. This had the potential to directly affect all four 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, 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).	0 790		

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0 790	Continued From page 21 The findings include: On October 7, 2021, between 10:10 a.m. and 11:00 a.m., survey staff toured the facility with the administrator about the fire extinguishers. KITCHEN AND 2ND FLOOR PORTABLE FIRE EXTINGUISHERS On October 7, 2021, between 10:10 a.m. and 11:00 a.m., portable fire extinguishers were located secured in the hallway of the 2nd floor and near the kitchen area behind closet doors. Both were observed with no tags attached to indicate required annual service and monthly inspections from this year or any previous years. The Administrator verified the information noted above. BASEMENT PORTABLE FIRE EXTINGUISHERS On October 7, 2021, between 10:10 a.m. and 11:00 a.m., portable fire extinguishers were not installed in the basement so that the travel distance to the nearest fire extinguisher does not exceed 75 feet as required. The administrator verified the information noted above as he explained that he bought a white colored portable fire extinguisher for the basement but has not installed it yet. Upon locating it, the Administrator presented the white portable fire extinguisher for review. It was not the correct type, but rather listed for special kitchen use. GARAGE PORTABLE FIRE EXTINGUISHERS On October 7, 2021, between 10:10 a.m. and 11:00 a.m., a portable fire extinguisher was located in the garage. The fire extinguisher gauge was noted to be in the "empty" position. In addition, the fire extinguisher did not bear the tag to indicate required annual service and monthly inspections from this year or any previous years. The Administrator verified the information noted above. No further information was provided.	0 790		

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0 790	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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.	0 810		

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0 810	Continued From page 23 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a fire safety and evacuation plan with all required content, to train residents on fire and evacuation, and to implement required fire drills. This has the potential to directly affect the safety of all current 4 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, 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: On October 7, 2021, between 11:17 a.m. to 12:00 p.m., survey staff received the facility fire safety and evacuation plan documentation for review. The facility fire safety emergency documentation failed to provide: -Documentation on facility-specific procedures for employee fire drill actions, fire protection procedures necessary for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are needing assistance during evacuation. The provided documentation was a generic fire policy procedure dated October 1, 2019, and was verified with the Administrator during the interview. -The required employee evacuation drills of twice	0 810		

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0 810	Continued From page 24 per year per shift with at least one evacuation drill every other month (total of six required annually). During interview at 11:30 a.m., the Administrator verified this finding by providing documentation of the last fire drill performed was on July 14, 2021, and asked for more information on fire evacuation drills that may be available that survey staff can send. -The required records on training of employees on fire safety and evacuation. During interview at 11:40 a.m., the administrator verified this finding by providing documentation of employee RTasks training/record system which noted training on licensure and assisted living facility policies, rather than specific to fire safety and evacuation. -The required records on training of residents who are capable of assisting their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, or relocation. During interview at 11:40 a.m., this was verified with the administrator. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900		

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	36395	A. BUILDING: _____ B. WING _____	10/07/2021

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0 900	Continued From page 25 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute an assisted living written contract with the residents to include all required content for one of one resident (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, 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	0 900		

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0 900	Continued From page 26 has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record lacked a written assisted living contract to include all terms concerning the provision of services as required: (1) housing, (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and, (3) the resident's service plan, if applicable R1's record lacked evidence the contract had been fully executed as the facility must have: - offered to prospective residents and provided to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - given a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum had been signed; and, - the facility must have offered the resident the opportunity to identify a designated representative. On October 6, 2021, at 11:45 a.m., R1 was observed to receive services including medication administration, meal prep, laundry and housekeeping. On October 7, 2021, at 9:15 a.m., the administrator confirmed all four residents lacked an assisted living contract as required. The licensee's Signing an Assisted Living Contract policy dated August 10, 2021, indicated a signed assisted living contract would be	0 900		

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0 900	Continued From page 27 executed by the facility for all residents. The policy lacked information on the required content of an assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470		

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01470	Continued From page 28 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees, unlicensed personnel (ULP)-C, and ULP-D with employee 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	01470		

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01470	Continued From page 29 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: ULP-C had a hire date of December 30, 2020. ULP-D had a hire date of August 21, 2020. Both employee records lacked documentation the following orientation topics were completed: -An overview of assisted living laws 144.G. -Review of the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On October 7, 2021, at 9:15 a.m. the administrator confirmed all employees had not yet completed the above listed required orientation topics. The licensee's Orientation of Staff and Supervisors & Content policy dated August 10, 2021, indicated all employees must complete the orientation to assisted living requirements before providing assisted living services to residents. The policy also indicated the orientation topics would include: -An overview of the appropriate Assisted Living statutes and rules. -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=F	144G.70 Subd. 2 Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 30 (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: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment with all required content for two of two residents (R1, R3) 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	01620		

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01620	Continued From page 31 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: R1 was admitted with diagnoses to include major depression, anxiety, and post traumatic stress disorder. R1's service plan dated August 19, 2021, indicated R1 received services from the assisted living provider that included housekeeping, laundry, medication administration, wound care, and supervision of wound care by an RN. R1's assessment dated September 19, 2021, failed to include the following required content: toileting pattern; a review of medications that included reason medication taken, difficulties resident faces in taking the medication, and resident preferences in how to take the medications; a review of medical, dental, and emergency room visits in the past 12 months including visits to primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility; a review of any report from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations in the last 12 months; initial vital signs; behavioral expressions of mental health conditions (eating disorder, agitation, depression with psychotic features); assessment of ability to smoke without causing burns, injury to resident, others, or damage to property; and alcohol and drug use (not prescribed). R3 had diagnoses to include schizophrenia, substance use disorder, and cannabis use disorder. R3 received services from the assisted	01620		

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01620	Continued From page 32 living provider that included medication management, housekeeping, laundry, and transportation. R3's assessment dated October 6, 2021, failed to include the following required content: toileting pattern, bowel, and bladder control; a review of medications that included reason medication taken; a review of any report from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations in the last 12 months; initial vital signs; and assessment of ability to smoke without causing burns, injury to resident, others, or damage to property. On October 7, 2021, at 9:55 a.m. RN-E stated she did not know all the required content for the assessment and assumed the assessment in the electronic health record contained the required content. The Assessments, Reviews, and Monitoring policy dated August 10, 2021 indicated the assessment must include all the elements as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.	01820		

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01820	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain current written or electronically recorded prescriptions for one of one resident (R1) with record 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 moved into the facility on March 8, 2021, with diagnoses to include major depression, anxiety, and post-traumatic stress disorder. R1's service plan dated August 19, 2021, indicated R1 received services from the assisted living provider that included housekeeping, laundry, medication administration, wound care, and supervision of wound care by a registered nurse (RN). R1's current medication list dated October 6, 2021, included ipratropium 0.03% nasal spray (both nostrils) scheduled at 8:00 a.m. and 8:00 p.m. to both nostrils, Robafen 100 milligrams (mg)/5 milliliters (ml) syrup (by mouth) as needed one time per day for cough, and tizanidine tablet 2 mg by mouth as needed every six hours four times per day for muscle spasm. R1's record lacked a prescriber order for ipratropium, Robafen, or tizanidine.	01820		

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01820	Continued From page 34 On October 7, 2021, at 9:30 a.m., RN-E stated she did not know the location of prescriptions for medications if not found in R1's chart. The Medications and Treatments policy dated August 10, 2021, indicated the facility required a prescription (prescriber order) for all medications the provider managed including over-the-counter medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were properly secured so only authorized personnel had access. 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).	01880		

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01880	Continued From page 35 The findings include: On October 6, 2021, at 11:45 a.m., the administrator (A)-A was observed providing medication administration to R1. Medication storage was inside the staff office room which was observed door wide open throughout the survey, on the main floor common area of the facility. A-A took the key to the medication storage from a metal box on the administrator's desk and unlocked the medication storage cabinet. A-A obtained R1's medications by popping from bubble pack into a paper medication cup, and using a computer medication administration record to verify each medication. A-A left the staff room and headed to the kitchen to administer the medications, leaving the bubble packs on his desk, the medication cabinet wide open, and the door to the staff office wide open. On October 6, 2021, at 11:55 a.m., A-A verified the key to the medication cabinet could be accessed by anyone as the staff room door does remain open all day. He also verified leaving all of the medications unattended when he left the room to administer R1's medication. A-A also verified at least one current resident (R3) had a diagnosis of substance abuse disorder. On October 7, 2021, at 9:10 a.m. the A-A verified the medications were not securely locked at all times. The licensee's Medication Storage policy dated August 10, 2021, indicated all medications would be kept securely locked and only authorized staff would have access to stored medications. No further information was provided.	01880		

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01880	Continued From page 36 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 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.	03030		

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03030	Continued From page 37 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make a timely report to the Minnesota Adult Abuse Reporting Center (MAARC) regarding an incident of self neglect for one of one resident (R2) with discharged record 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 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: R2 was discharged to homelessness, leaving per R2's preference, without needed medications; the licensee failed to report the incident of self-neglect in a timely manner. R2's Resident Notes dated September 19 and 20, 2021, completed by the administrator (A)-A and registered nurse (RN)-E indicated R2 was admitted to licensee facility on September 19, 2021, with diagnoses of schizophrenia and diabetes. A-A was requested by R2's girlfriend and case manager to pick up R2. R2 was found by A-A sleeping outside with no shirt or shoes. R2 agreed to come to licensee facility. R2 was offered housing on September 19, 2021. An assisted living contract was never executed and a nursing assessment was not conducted due to R2 refusal and non-compliance. R2 was non-compliant with medication administration with the exception of one injection of Risperdal	03030		

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EVYGABS HEALTHCARE SYSTEMS LLC	20604 ENFIELD AVENUE NORTH FOREST LAKE, MN 55025

(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
03030	Continued From page 38 (anti-psychotic), administered by the licensee's registered nurse (RN-E). R2's Discharge Summary dated October 4, 2021, completed by RN-E, indicated R2 was discharged on September 20, 2021, to return to live on the street. The Discharge Summary listed R2's behavior as physically and verbally aggressive. The Discharge Summary included: Concerned about decision to care for self and make good decisions. On October 7, 2021, at 9:10 a.m., A-A confirmed he did not call this incident of self neglect into MAARC in a timely manner but would make a report now. A-A indicated he had notified R2's case manager the resident left to go back to homelessness. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated August 10, 2021, indicated the licensee's staff were mandated reporters and the facility would support protection and safety through the state's system for reporting suspected vulnerable adult maltreatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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: *10/06/21*
Time: 11:03:54
Report: 1004211224

Food and Beverage Establishment Inspection Report

Location:
EVYGABS HEALTHCARE SYSTEMS
20604 ENFIELD AVENUE NORT
FOREST LAKE, MN55025
Washington County

Establishment Info:
ID #: N000001
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/21

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.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

ESTABLISHMENT DOES NOT RECORD EMPLOYEE ILLNESS. EMPLOYEE REPORTS OF VOMITING, DIARRHEA, OR OTHER ACUTE GASTROINTESTINAL ILLNESS MUST BE RECORDED ON EMPLOYEE ILLNESS LOG, INCLUDING DATE OF ONSET, DAYS MISSED FROM WORK, RETURN DATE, AND ALL SYMPTOMS.

Comply By: 10/06/21

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS AND RAW BACON FOUND STORED ABOVE AND COMMINGLED WITH READY-TO-EAT ITEMS. STORE RAW ANIMAL FOODS SEPARATELY AND BELOW ALL READY-TO-EAT ITEMS.

Comply By: 10/06/21

4-700 Sanitizing Equipment and Utensils

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

ESTABLISHMENT IS NOT SANITIZING UTENSILS/DISHES AFTER MANUALLY WASHING AND RINSING. ALL FOOD-CONTACT SURFACES OF UTENSILS AND EQUIPMENT MUST BE EFFECTIVELY WASHED, RINSED, AND SANITIZED USING AN APPROVED SANITIZING

METHOD.

Comply By: 10/06/21

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OPENED PACKAGES OF DELI MEAT, SALSA, AND OTHER ITEMS FOUND WITHOUT DATE MARKING IN THE REFRIGERATOR. ENSURE ALL COLD, TCS FOOD ITEMS ARE MARKED WITH THE DATE THEIR PACKAGING IS OPENED, AND THAT THEY ARE USED OR DISCARDED WITHIN 7 DAYS.

Comply By: 10/06/21

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE TEMPERATURE INDICATOR (EX. MAXIMUM REGISTERING THERMOMETER OR SINGLE-USE TEMPERATURE SENSITIVE STRIPS) FOR VERIFYING SANITIZING TEMPERATURE OF DISH MACHINE. PROVIDE AND USE FREQUENTLY TO ENSURE A SURFACE TEMPERATURE OF 160*F IS REACHED.

Comply By: 10/06/21

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO SANITIZER TEST KIT/STRIPS FOR CHLORINE BLEACH. PROVIDE AND USE FREQUENTLY TO ENSURE A CONCENTRATION OF 50-100PPM IS MAINTAINED FOR SANITIZING. *STRIPS LEFT ON SITE WITH OPERATOR.

Comply By: 10/06/21

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

ESTABLISHMENT MUST DESIGNATE A BASIN OF THE 2 BASIN KITCHEN SINK FOR HANDWASHING AND ONLY USE THE DESIGNATED BASIN FOR HANDWASHING PURPOSES, MAINTAINING ACCESS AT ALL TIMES.

Comply By: 10/06/21

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CFPM. OPERATOR STATED THEY ARE IN THE PROCESS OF HAVING SOMEONE TAKE AN APPROVED FOOD SAFETY COURSE AND BECOMING CERTIFIED.

Comply By: 10/06/21

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

FLOUR, SUGAR, AND POTATOES FOUND STORED ON THE FLOOR OF THE PANTRY. ENSURE ALL FOOD ITEMS ARE STORED A MINIMUM OF 6 INCHES OFF THE GROUND. *CORRECTED ON SITE.

Corrected on Site

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.

DISH MACHINE DOES NOT HAVE AN EFFECTIVE SANITIZE CYCLE (NSF STANDARD 3) AND STATES "NOT INTENDED FOR LICENSED FOOD ESTABLISHMENTS". REPLACE WITH A MODEL THAT HAS REQUIRED SANITIZE CYCLE THAT PROVIDES A UTENSIL SURFACE TEMPERATURE OF 160*F OR ABOVE.

Comply By: 10/06/21

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO SIGN OR POSTER LOCATED AT HANDWASHING SINK NOTIFYING EMPLOYEES TO WASH THEIR HANDS. PROVIDE AND MAINTAIN.

Comply By: 10/06/21

Food and Equipment Temperatures

Process/Item: CHILI
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: CUT LETTUCE
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

Process/Item: AMBIENT TEMPERATURE
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION SURVEY.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-PREVENTING BAREHAND CONTACT
-CERTIFIED FOOD PROTECTION MANAGER CERTIFICATION
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DATE MARKING
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION
-FOOD PREPARATION (PREPARED AND SERVED SAME DAY)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-ALL VIOLATIONS ON THIS REPORT

*FLOORS ARE WOOD AND CEILING IS "POPCORN" TEXTURE. BOTH ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

**EMPLOYEE ILLNESS: THE EMPLOYEE ILLNESS POLICY SHOULD, AT THE MOST BASIC LEVEL, STATE THAT EMPLOYEES EXHIBITING SYMPTOMS OF DISEASE THAT IS TRANSMISSIBLE BY FOOD (I.E. VOMITING, DIARRHEA OR OTHER ACUTE GASTROINTESTINAL ILLNESS; JAUNDICE, HEPATITIS A, E.COLI, SHIGELLA, SALMONELLA, OR NOROVIRUS) MUST REPORT THESE SYMPTOMS TO THEIR EMPLOYER. EMPLOYEES EXHIBITING VOMITING, DIARRHEA, OR OTHER ACUTE GASTROINTESTINAL ILLNESS MUST BE EXCLUDED FROM WORK UNTIL THEY HAVE BEEN SYMPTOM FREE FOR A MINIMUM OF 24 HOURS. EMPLOYEE ILLNESSES MUST BE RECORDED ON EMPLOYEE ILLNESS LOG, INCLUDING DATE OF ONSET, DAYS MISSED FROM WORK, RETURN DATE, AND ALL SYMPTOMS

***IF ANY CUSTOMER COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455

Food and Beverage Establishment Inspection Report

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 1004211224 of 10/06/21.

Certified Food Protection Manager: NONE

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
GABRIEL

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us

Report #: 1004211224

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	6	**Date**	10/06/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:03:54
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
EVYGABS HEALTHCARE SYSTEMS	20604 ENFIELD AVENUE NORT	FOREST LAKE, MN	55025	

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
N000001		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	X	Contamination prevented during food prep, storage & display	X	
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	X	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:** 10/06/21

Inspector (Signature) Molly Dougherty