Electronically Delivered

May 1, 2023

Licensee
Cherrywood Of Big Lake
171 Henry Road
Big Lake, MN 55309

RE: Project Number(s) SL28114015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 29, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH 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 (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.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

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

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

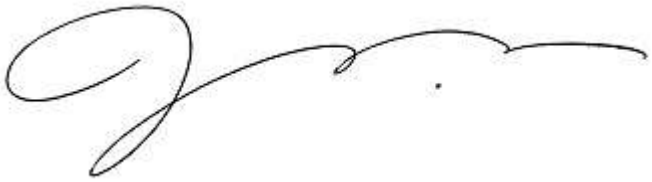
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28114015 On March 27, 2023, through March 29, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 16 active residents; all 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 27, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 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	0 580		

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0 580	Continued From page 2 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 appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 16 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: During the entrance conference on March 27, 2023, at 10:45 a.m., licensed assisted living director (LALD)-C stated weekly quality management meetings were held, the last one held was Wednesday of last week, March 22, 2023, and the current topic was staffing for the weekend. On March 29, 2023, at 4:10 p.m., LALD-C stated the monthly staff meeting was where they discuss	0 580		

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0 580	Continued From page 3 quality management topics, but the meeting notes had been discarded. LALD-C stated there was no quality management documentation to provide. The licensee's 2.31 Quality Management Project Policy dated August 1, 2021, indicated to document the quality management process; keep all related documents on file for at least two years. The quality management documentation should be made available, upon request, to MDH surveyors and OHFC investigators. At least one performance improvement project needs to be always in process. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	0 650		

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0 650	Continued From page 4 (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of five employees (unlicensed personnel (ULP)-G, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-G was hired on November 5, 2021, to provide direct care services to the licensee's residents. ULP-G's employee record lacked the following: - documentation of an annual performance review that identified areas of improvement needed and training needs. ULP-H was hired on April 30, 2020, under the comprehensive home care license, and began providing direct care services to the licensee's	0 650		

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0 650	Continued From page 5 residents August 1, 2021 under the assisted living with dementia care license. ULP-H's employee record lacked the following: -documentation of an annual performance review that identified areas of improvement needed and training needs. On March 28, 2023, at 10:50 a.m., licensed assisted living director (LALD)-C stated ULP-G did not have an annual performance review completed. On March 29, 2023, at 2:55 p.m., HM-D stated ULP-H did not have an annual performance review completed. HM-D stated she was newer to this position and trying to catch up on all the annual reviews and education missed by the employees. The licensee's 4.35 Employee Evaluation Policy dated August 1, 2021, indicated all staff of [the facility] will be given an employee evaluation at least annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 650		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800		

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0 800	Continued From page 6 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. 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). Findings include: On March 28, 2023, between 12:30 p.m. and 1:15 p.m., survey staff toured the facility with the housing manager (HM)-D. During the facility tour, survey staff observed an accumulation of snow on the exit path outside three marked exits. All paths of egress must be maintained and clear of obstructions to allow exiting for occupants and access for emergency responders in the event of an emergency. This deficient condition was verified by HM-D accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		

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01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01500		

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01500	Continued From page 8 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment, including required annual training content, for three of five employees (licensed practical nurse (LPN)-E, unlicensed personnel (ULP)-G, ULP-H). In addition, the licensee failed to include all required training topics for the annual training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01500		

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01500	Continued From page 9 The findings include: LPN-E LPN-E was hired on September 10, 2020, under the comprehensive home care license, and began providing direct care services to the licensee's residents August 1, 2021 under the assisted living with dementia care license. On March 28, 2023, at 7:15 a.m., the evaluator observed LPN-E assist R2 with morning cares and administer R2's scheduled morning medications. LPN-E's record contained seven and a half hours of the required eight hours of annual training. LPN-E's record lacked annual training on the following topics: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procudures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULPs ULP-G was hired on November 5, 2021, to provide direct care services under the licensees assisted living with dementia care license. On March 28, 2023, at 7:00 a.m., the evaluator observed ULP-G assist R1 with morning cares and administer R2's scheduled morning medications. ULP-H was hired on April 30, 2020, under the	01500		

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01500	Continued From page 10	01500		

comprehensive home care license, and began providing direct care services to the licensee's residents August 1, 2021 under the assisted living with dementia care license.

ULP-G and ULP-H's records contained zero hours of the required eight hours of annual training.

ULP-G and ULP-H's records lacked evidence that they had successfully completed annual training as required, in the following areas:
- reporting maltreatment of vulnerable adults;
- review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
- review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated material and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;
- review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures;
- effective approaches to use when problem solving while working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;
- review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and
- principles of person-centered planning with

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01500	Continued From page 11 service delivery and how they apply to direct support services provided by the staff person. On March 29, 2023, at 1:40 p.m., licensed assisted living director (LALD)-C stated due to a recent change in housing manager some of the employee training had slipped through the cracks. On March 29, 2023, at 2:55 p.m., housing manager (HM)-D stated LPN-E was missing two of the required trainings and ULP-G and ULP-H both did not have any of their annual training completed. The licensees 5.06 Annual Required Staff Training policy dated August 1, 2001, indicated the following training elements must be included every 12 months to all staff who perform direct care services: -Training on reporting maltreatment of vulnerable adults. -Review of the assisted living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights. -Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; The need for and use of protective gloves, gowns, and mask; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental services; and reporting communicable diseases. -Review of the facilities policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. -Principles of person-centered planning with service delivery and how they apply to direct	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01500	Continued From page 12 support services provided by the staff person. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01620	Continued From page 13	01620		

nurse (RN) completed a comprehensive reassessment for change of condition for one of one resident (R2).

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's diagnoses included diabetes mellitus (high blood glucose levels), essential hypertension (high blood pressure), and polyneuropathy (damage to multiple peripheral nerves).

R2's service plan dated June 29, 2022, indicated R2 received the following services: bathing, dressing, toileting, transfer assist of one with transfer belt, housekeeping, laundry services, blood glucose monitoring, and insulin administration.

R2's 90-day assessment dated, January 11, 2023, indicated R2 required limited assistance for transfers.

On March 28, 2023, at 7:15 a.m., the evaluator observed licensed practical nurse (LPN)- E assist R2 with transfer using the EZ stand lift (mechanical lift).

R2's record lacked documentation to indicate a RN had completed a reassessment of R2's change in condition regarding transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01620	Continued From page 14 On March 28, 2023, at 7:15 a.m., LPN-E stated R2 had been using the EZ stand lift for transfers for several weeks due to the decline of leg strength. On March 28, 2023, at 7:40 a.m., R2 stated his legs do not work anymore and he uses the machine for transfers. R2 stated he has been using the mechanical lift for several weeks on a regular basis. On March 29, 2023, at 9:10 a.m., clinical nurse supervisor (CNS)-A stated he had a conversation with R2 about a week ago concerning the EZ stand and changing R2's service plan but did not document this conversation in R2's record. CNS-A stated he had not completed the change of condition assessment for R2. On March 29, 2023, at 9:25 a.m., housing manager (HD)-D stated R2 had been consistently using the EZ stand for at least two to three weeks. The licensee's 6.19 Resident Change in Condition or Need policy dated August 1, 2021, indicated when changes in condition or needs are identified, a Registered Nurse will initiate a change in condition assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01650	Continued From page 15 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of two residents (R2). 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	01650		

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	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01650	Continued From page 16	01650		

cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On March 28, 2023, at 7:15 a.m., the surveyor observed licensed practical nurse (LPN)-E assist R2 with transfers, blood glucose monitoring, and medication adminstration.

R2's service plan dated June 29, 2022, indicated R2 received the following services: dressing, bathing, transfer assist of one with transfer belt, toileting, laundry, housekeeping, insulin administration, and blood glucose monitoring.

R2's service plan lacked the following required content:
- the fees for services, and the frequency of each service according to the resident's current assessment and resident preferences;
- the identification of staff or categories of staff who will provide the services;
- the schedule and methods of monitoring assessments of the resident;
- the schedule and methods of monitoring staff providing services; and
- a contingency plan that includes:
- the action to be taken if the scheduled service cannot be provided;
- information and a method to contact the facility;
- the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;

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	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01650	Continued From page 17	01650		

and
- the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B,145C, and declarations made by the resident under those chapters.

On March 27, 2023, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated the service plan for R2 did not meet all the requirements. CNS-A stated almost all of the other resident service plans have been updated but R2's service plan had not been updated yet.

The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated the licensee would include:
- A description of the services that are to be provided based on the most recent assessment and resident preferences
- Fees for services to be provided
- The frequency of each service to be provided based on the most recent assessment and resident preferences
- An identification of staff or categories of staff who will be providing the services
- A schedule and method for the next plan assessment or monitoring
- A schedule and method for the next plan monitoring of staff providing services
- A contingency plan that includes:
- Actions licensee will take if scheduled services cannot be provided
- Information regarding how the resident can contact licensee
- The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition.
- Identification and contact information of who the resident has authorized, if any, to sign for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01650	Continued From page 18 resident in an emergency - How the facility will support documented resident health care directive decisions, if any- including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened-on date for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01890	Continued From page 19 R2 had diagnoses including type II diabetes mellitus. R2's prescriber's orders signed June 11, 2022, directed: -insulin aspart (Novolog) pen 100 unit/ml (milliliter) inject 8 units once daily plus sliding scale subcutaneously (under the skin) three times a day. -insulin glargine (Lantus) pen 100 unit/ml inject 14 units once daily at bedtime. On March 28, 2023, at 7:15 a.m., the evaluator observed licensed practical nurse (LPN)-E provide blood glucose monitoring, and medication administration services to R2. The evaluator observed the contents of R2's medication cabinet with LPN-E and observed both the Novolog and Lantus pens lacked a date indicating when the insulins were opened. On March 28, 2023, at 7:25 a.m., LPN-E stated insulin pens should be dated when opened. Novolog pen manufacturer instructions dated March 2023, directed the medication should be discarded 28 days after opened. Lantus pen manufacturer instructions dated as revised December 2020, directed the medication should be discarded 28 days after opened. The licensee's 7.10 Medications Storage policy dated August 1, 2021, indicated the licensee will store medications consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01890	Continued From page 20 days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

(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
01940	Continued From page 21 review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1, R2). 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: R1 R1's diagnoses included diabetes mellitus (high blood glucose levels), essential hypertension (high blood pressure), and progressive vascular leukoencephalopathy (rare brain infection). R1's service plan dated January 1, 2023, indicated R1 received treatments including blood glucose monitoring. R1's Medication Administration Report, dated March 24, 2023, through March 25, 2023, indicated R1 had blood glucose monitored each day. On March 28, 2023, at 7:00 a.m., the evaluator observed unlicensed personnel (ULP)-G check R2's blood glucose. ULP-G stated there were no instructions listed for when to notify the nurse of a low or high blood glucose reading. R2 R2's diagnoses included diabetes mellitus (high blood glucose levels), essential hypertension	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01940	Continued From page 22 (high blood pressure), and polyneuropathy (damage to multiple peripheral nerves). R2's service plan dated June 29, 2022, indicated R2 received the following services: bathing, dressing, toileting, transfer assistance, housekeeping, laundry services, blood glucose monitoring, and insulin administration. R2's Medication Administration Report, dated March 23, 2023, through March 24, 2023, indicated R2 had blood glucose monitored each day with insulin administration. On March 28, 2023, at 7:15 a.m., the evaluator observed licensed practical nurse (LPN)-E check R2's blood glucose. LPN-E stated there were no parameters listed for the blood glucose monitoring service or any indication when to notify the nurse. LPN-E stated there are standing orders for what to do when the blood glucose is too low, but nothing for when it is too high, and these instructions are not listed in the service. R1's and R2's records both lacked development of an induvidualized treatment and therapy plan including the following required content: - documentation of specific instructions to include blood glucose parameters and procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services. On March 28, 2023, at 9:15 a.m., clinical nurse supervisor (CNS)-A stated parameters were only added to the blood glucose monitoring service if the provider orders them. CNS-A stated the ULPs administering medications would not know when to notify the nurse of a high or low blood glucose reading but should reference the standing orders	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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01940	Continued From page 23 for low blood glucose. CNS-A stated the standing orders were not written on the service. The licensees 7.05 Treatment and Therapy Management Plan policy dated, August 1, 2021, indicated the licensee will maintain a current individualized treatment and therapy record for each resident which must contain the following: -documentation of specific resident instructions relating to the treatments or therapy administration. -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. -any resident-specific requirements relating to documentation of treatment and therapy received. -monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system	02040		

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	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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02040	Continued From page 24 by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to mitigate hazards that were identified on the hazard vulnerability assessment of the physical environment. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On March 28, 2023, between 12:30 p.m. and 1:15 p.m., survey staff toured the facility with the housing manager (HM)-D. During the facility tour, survey staff observed in two open kitchen/dining common areas, commercial-type hot water dispensers (directly connected to the water system) were readily accessible to residents (all dementia care) which posed scalding concerns. The findings were evident as the HM-D and survey staff observed that the power was on for both hot water dispensers during the tour. On March 28, 2023, at approximately 1:15 p.m., records were provided for review. Records were reviewed by survey staff on March 28, 2023, between 1:15 p.m. and 2:10 p.m. A hazard vulnerability assessment form was included in the documentation provided. This	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

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02040	Continued From page 25 assessment identified the hot water dispensers as a hazard with mitigation listed to shut off the power when not in use. Between approximately 1:30 p.m. and 1:45 p.m., survey staff observed times when employees were not present in these open kitchen/dining common areas which were readily accessible to residents. The licensee failed to turn off the power for these hot water dispensers as directed in their mitigation plan. This deficient condition was verified by HM-D accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 26 of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to resident's legal and designated representatives at time of move in for two of two residents (R1, R2). 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 facility currently held an Assisted Living with Dementia Care license for a capacity of 20	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28114	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRYWOOD OF BIG LAKE	171 HENRY ROAD BIG LAKE, MN 55309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 27 residents. R1 R1's diagnoses included diabetes mellitus (high blood glucose levels), essential hypertension (high blood pressure), and progressive vascular leukoencephalopathy (rare brain infection). R2 R2's diagnoses included diabetes mellitus (high blood glucose levels), essential hypertension (high blood pressure), and polyneuropathy (damage to multiple peripheral nerves). R1 and R2's records lacked evidence the resident or residents' representative were provided the additional required policies and procedures for assisted living facilities with dementia care. On March 28, 2023, at 3:00 p.m., licensed assisted living director (LALD)-C stated the dementia care disclosure was provided to all the residents or resident's family but not the actual dementia care policies. The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies policy dated August 1, 2021, indicated the licensee must provide these policies and procedures to residents and the resident's legal and designated representatives at the time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

DEPARTMENT OF HEALTH

Type: Full
Date: *03/27/23*
Time: 11:40:39
Report: 1037231081

Food and Beverage Establishment Inspection Report

Location:
Cherrywood Of Big Lake
171 Henry Road
Big Lake, MN55309
Sherburne County, 71

Establishment Info:
ID #: 0037652
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202577445
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.

4-300 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.

EMPLOYEE STATED THEY HAVE COLOR CHANGING HEAT TEST STRIPS FOR THE DISHWASHER BUT WAS UNABLE TO FIND THEM. HAVE TEST STRIPS AVAILABLE IN BOTH KITCHENS AND MAINTAIN A LOG WHEN TESTING IS COMPLETED TO VERIFY TEMPERATURES ARE A MINIMUM OF 160 DEG F.

Comply By: 04/03/23

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.

PROVIDE A TEST KIT TO MEASURE CHLORINE SANITIZER CONCENTRATION IN EACH KITCHEN.

Comply By: 04/03/23

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.

BINS OF DRY FOODS WERE BEING STORED ON THE FLOOR IN THE DRY STORAGE ROOM. STORE ALL FOOD ITEMS AT LEAST 6 INCHES ABOVE THE FLOOR.

Comply By: 04/03/23

Food and Beverage Establishment Inspection Report

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.

REMOVE HOUSEHOLD CROCKPOT ROASTER AND ELECTRIC GRIDDLE. REPLACE WITH ANSI CERTIFIED EQUIPMENT IF NEEDED.

Comply By: 04/03/23

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 158 Degrees Fahrenheit - Location: HAMBURGER PATTY -171 KITCHEN
Violation Issued: No

Process/Item: Cooking
Temperature: 208 Degrees Fahrenheit - Location: MIXED VEGETABLES -171 KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: PRECOOKED DICED POTATOES -171 KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: MILK JUG -171 KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK JUG -177 KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 34 Degrees Fahrenheit - Location: EGG SALAD -177 KITCHEN
Violation Issued: No

Process/Item: Cooking
Temperature: 159 Degrees Fahrenheit - Location: BURGER PATTY -177 KITCHEN
Violation Issued: No

Process/Item: Cooking
Temperature: 210 Degrees Fahrenheit - Location: MIXED VEGETABLES -177 KITCHEN
Violation Issued: No

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

Type: Full
Date: *03/27/23*
Time: 11:40:39
Report: 1037231081
Cherrywood Of Big Lake

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 inspection report number 1037231081 of 03/27/23.

Certified Food Protection Manager: VICKI JOHNSON

Certification Number: 28021 Expires: 06/12/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037231081

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	0	Date	03/27/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:40:39
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Cherrywood Of Big Lake	171 Henry Road	Big Lake, MN	55309	3202577445

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037652		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		
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:** 03/27/23

Inspector (Signature) Michelle L Thomas