Electronically Delivered

August 9, 2023

Licensee
Living Hope Homes Ellies Garden View
13115 50th Street South
Afton, MN 55001

RE: Project Number(s) SL38664015

Dear Licensee:

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

The Minnesota Department of Health completed an initial survey on July 25, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state 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 . . ."

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state 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).

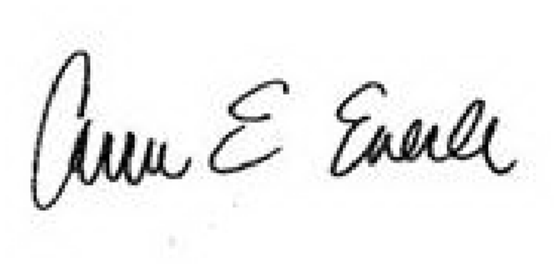
Please address your cover letter for reconsideration requests to:

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/or state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Carrie Euerle, Supervisor
State Rapid Response Team
Email: carrie.euerle@state.mn.us
Telephone: 651-242-8846 Fax: 651-215-6894

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38664	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES ELLIES GARDEN VIEW	13115 50TH STREET SOUTH AFTON, MN 55001

(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: SL#38664015 On July 24 through July 25, 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 and investigation, there were four residents receiving services under the provider's Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the 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 July 25, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) 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	0 485		

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0 485	Continued From page 2 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to post a menu one week in advance and failed to make the menu available to all residents. This had the potential to affect all residents receiving services from the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: On July 25, 2023, at 1:00 p.m. the surveyor observed no weekly menu posted in a central area. The surveyor requested a copy of the current and next week's menu.	0 485		

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0 485	Continued From page 3 A menu was not provided. On July 25, 2023 at 2:00 p.m., administrator (AD)-B stated the facility did not currently have a weekly menu prepared at least one week in advance and available to all residents. The menu was planned, but it was the facility practice to file it in a binder in the kitchen area and not have it on display or a copy given to each resident. The licensee policy titled 12.01 Food Service & Menu Planning indicates that Menus will be prepared at least one (1) week in advance and made available to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 485		
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 residents.	0 680		

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0 680	Continued From page 4 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to post an emergency disaster plan prominently, as well as to develop an emergency preparedness plan (EPP) with all the required components included in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: On July 24, 2023 at 2:00 p.m., the surveyor requested the licensee's emergency preparedness plan and components. The licensed assisted living administrator (LALD)-A provided the surveyor with a white three ring binder, titled "Emergency Plan", which was in the nurse's office area near the first-floor	0 680		

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0 680	Continued From page 5 common area. The licensee's Fire and Emergency Evacuation Plan lacked the following required content: -Emergency officials contact information. -Communication plan must include contact information for the following: Federal, State, tribal, regional & local Emergency Preparedness (EP) staff. During an interview on July 25, 2023, at 3:00 p.m., (LALD)-A verified the EPP did not have all the required components of Appendix Z and was not prominently displayed. Although, LALD-A verified understanding the requirement that the licensee will have in place an emergency preparedness plan that is in alignment with facility's requirement to comply with CMS Appendix Z. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance Policy Effective Date: August 1, 2021, states a communications plan will focusing on staff, entities under arrangement, other Long Term Care providers (LTC) providers, volunteers, family members, state and federal contacts, and other sources of assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 6 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain working smoke alarms in the hallways of the lower-level floor. This has the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 7 The findings include: On July 24, 2023, approximately from 1:45 p.m. to 2:45 p.m. survey staff toured the home with the administrator (AD)-G and the licensed assisted living director (LALD)-A. During the tour, survey staff observed two mounting plates on the ceiling of the lower-level floor hallways with exposed wires and no smoke alarms. The findings were verbally and physically verified by the AD-G and the LALD-A accompanying the home tour. On July 24, 2023, at approximately 3:30 p.m., during the exit interview, AD-G and the LALD-A acknowledged the above findings. 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	0 790		

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0 790	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 24, 2023, approximately from 1:45 p.m. to 2:45 p.m., survey staff toured the home with the administrator (AD)-G and the licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: -The portable fire extinguishers (PFE) had not been inspected and annually serviced. The findings were evident as the lower-level PFE had a tag with a record of service date of September 2020, and the main-level PFE had a tag with an annual service date of February 2022. Both tags lacked records to show the monthly visual inspections. Survey staff explained to the AD-G and the LALD-A that the portable fire extinguishers must be annually serviced by a qualified vendor and be provided with monthly visual inspection or "quick checks" of each	0 790		

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0 790	Continued From page 9 extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. -The PFE was improperly located and installed for easy visibility and ready access for use. The PFE was not visible on the main-level floor of the home during the tour of the main-level floor and survey staff inquired about one. The AD-G located the PFE inside the kitchen pantry behind the kitchen with a door mounted at approximately 6.5 feet above the floor. Survey staff explained that the highest point of the PFE must be mounted at a maximum of 5 feet above the floor and the PFE must be relocated or have proper signage so it is visible and staff to have ready access. All findings were visually and verbally verified by the LALD-A and the AD-G accompanying the home tour. On July 24, 2023, at approximately 3:30 p.m., during the exit interview, AD-G and the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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,	0 800		

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0 800	Continued From page 10 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 24, 2023, approximately from 1:45 p.m. to 2:45 p.m. survey staff toured the home with the administrator (AD)-G and the licensed assisted living director (LALD)-A. During the tour, survey staff observed the following: - The toilet traps inside the three lower-level bathrooms were completely dried out, which had the potential to allow sewer gas to enter the home environment creating unsafe and health risks to residents and employees. The LALD-A confirmed the findings as she stated that the lower-level floor rooms are not used by	0 800		

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0 800	Continued From page 11 residents and/or employees. Survey staff explained that the lower-level floor is still part of the same home and shares the mechanical/plumbing systems and must be maintained for a clean and safe environment for residents, staff, and visitors. -Dead flies (on the floor, inside the toilet bowl, and the light fixture) were observed inside the bathroom of the bedroom adjacent to the lower-level stairway. -The staff restroom adjacent to the laundry room on the lower-level had a toilet bowl that was soiled/covered with black water (wastewater) in color. -The stairway connecting the lower- and upper-level floors was used to store boxes and storage items obstructing the means of egress and proper use of the stairway for emergencies. -Resident bedroom door #3 failed to latch when closed. -The hallway door to the deck (next to bedroom #2) on the main floor was not in working order. The LALD-A stated it worked at one point. All findings were visually and verbally verified by the LALD-A and the AD-G accompanying the home tour. On July 24, 2023, at approximately 3:30 p.m., during the exit interview, AD-G and the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 (21) days	0 800		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38664	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES ELLIES GARDEN VIEW	13115 50TH STREET SOUTH AFTON, MN 55001

(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
0 810	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the correct frequency of employee evacuation drills and a site-specific fire safety and evacuation plan. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 24, 2023, at approximately 2:45 p.m., survey staff received the home's fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-A. At approximately 3:30 p.m., document review and interview with the LALD-A and the administrator (AD)-G indicated the following findings: -Document review indicated that the home's fire policy, page 21, dated August 1, 2021, lacked site-specific fire protection procedures for employees. The documentation was incorrectly written referring to magnetic holders will automatically close to contain smoke and fire which the home did not have. - Document review indicated that evacuation drill	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38664	A. BUILDING: _____ B. WING _____	07/25/2023

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LIVING HOPE HOMES ELLIES GARDEN VIEW	13115 50TH STREET SOUTH AFTON, MN 55001

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0 810	Continued From page 14 records provided for review showed an insufficient number of employee fire safety and evacuation drills performed to date from the licensure issuance date, April 2022. Drill records received for review were dated 9/26/2022 (10:00 a.m.), 9/26/2022 (11:00 a.m.), and 3/3/2023 (2:45 p.m.). Survey staff explained to the LALD-A and the AD-G that the minimum required frequency of two evacuation drills for employees must be twice per year per shift with at least one evacuation every other month. On July 24, 2023, at approximately 3:30 p.m., during the exit interview, AD-G and the LALD-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01880 SS=D	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 document review, the licensee failed to ensure security and accountability for the overall management, control, and disposition of prescribed medication for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38664	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES ELLIES GARDEN VIEW	13115 50TH STREET SOUTH AFTON, MN 55001

(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
01880	Continued From page 15 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's diagnosis included type II diabetes mellitus, aftercare following surgical amputation (primary) - Right below knee and major depressive disorder. R1 started receiving services from the licensee on July 7, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R1's medication administration record (MAR) included, but was not limited to, an order dated October 20, 2022, for Novolog (Asp) Flexpen 100 units/daily. On July 24, 2023, at 2:00 p.m., the surveyor observed a small refrigerator in the unlocked nurse's office with no locking mechanism to secure the door. Medication inside the refrigerator included an unopened Novolog Flexpen 100u boxes for R1. During an interview on July 25, 2023, at 11:00 a.m. registered nurse (RN)-C stated that per licensee policy the resident medication should be in a locked storage container. The licensee's policy titled 7.11 Medication Storage Effective Date: August 1, 2021, indicated medications managed outside of a resident's private "living space" must be in securely locked	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38664	A. BUILDING: _____ B. WING _____	07/25/2023

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LIVING HOPE HOMES ELLIES GARDEN VIEW	13115 50TH STREET SOUTH AFTON, MN 55001

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01880	Continued From page 16 and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. Medications will be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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 document review, the licensee failed to ensure security and accountability for the overall management, control, and disposition of prescribed medication for one of one resident (R1). This had the potential to affect all residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38664	A. BUILDING: _____ B. WING _____	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES ELLIES GARDEN VIEW	13115 50TH STREET SOUTH AFTON, MN 55001

(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
01890	Continued From page 17 situation has occurred only occasionally). The findings include: R3's diagnosis included chronic obstructive pulmonary disease (COPD), aortic valve replacement, and seizure disorder. R3 started receiving services from the licensee on October 18, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. On July 25, 2023, at 10:00 a.m. the surveyor observed a cloth bag in an unlocked cabinet of the desk in the nurse's office. The bag contained 18 medication containers, 6 of which were expired, and all containers were labeled for R3. During an interview on July 25, 2023, at 11:00 a.m. registered nurse (RN)-C stated that expired and unused medication should have been stored and disposed of per policy guidelines. RN-C had no knowledge of the medications and was unaware that the bag of expired medication was in the desk. The licensee's policy titled 7.11 Medication Storage Effective Date: August 1, 2021, indicated medications managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. Medications will be stored consistent with manufacturer's recommendations. The licensee's policy titled 7.23 Medication Disposal Effective Date: August 1, 2021, indicated medications managed by Living Hope	01890		

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01890	Continued From page 18 Homes will be disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the containers will be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *07/25/23*
Time: 13:51:02
Report: 1023231139

Food and Beverage Establishment Inspection Report

Location:
Living Hope Homes Ellies Garde
13115 50th Street S
Afton, MN55001
Washington County, 82

Establishment Info:
ID #: 0041344
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

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.

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.

OBSERVED RAW SHELL EGGS STORED OVER READY TO EAT FOODS. OPERATOR MOVED EGGS TO SAFE LOCATION DURING INSPECTION.

Comply By: 07/25/23

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

OPERATOR STATED NO THERMOMETER AVAILABLE. ACQUIRE AND USE THIS DEVICE TO ENSURE SAFE FOOD TEMPERATURES.

Comply By: 07/25/23

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

OBSERVED WOODEN SPOONS. OPERATOR DISCARDED WOODEN UTENSILS.

Comply By: 07/25/23

Type: Full
Date: *07/25/23*
Time: 13:51:02
Report: 1023231139
Living Hope Homes Ellies Garde

Food and Beverage Establishment Inspection Report

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED FOOD DEBRIS ON TOP OF MICROWAVE INTERIOR.

Comply By: 07/25/23

Surface and Equipment Sanitizers

Chlorine: = at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

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

Hot Water: = at 155 Degrees Fahrenheit
Location: ANSI 184 DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Freezer
Temperature: Degrees Fahrenheit - Location: REACH IN FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

FOOD SERVICE IS PROVIDED BY FACILITY STAFF. FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS
MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE

- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS
- ANSI 184 DISH WASHER

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 1023231139 of 07/25/23.

Certified Food Protection Manager: LANIA OYEN

Certification Number: 99240 Expires: 06/13/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

LANIA OYEN
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us