Electronically Delivered

May 22, 2023

Licensee
Shoreview Senior Living LLC
4710 Cumberland Street
Shoreview, MN 55126

RE: Project Number(s) SL28875015

Dear Licensee:

On May 11, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 12, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 12, 2023 survey.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on January 12, 2023, found not corrected at the time of the May 11, 2023, follow-up survey and/or subject to penalty assessment are as follows:

1880-Storage Of Medications-144g.71 Subd. 19

The details of the violations noted at the time of this follow-up survey completed on May 11, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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.

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker's at 651-201-3789.

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.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28875	A. BUILDING: _____ B. WING _____	R 05/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREVIEW SENIOR LIVING LLC	4710 CUMBERLAND STREET SHOREVIEW, MN 55126

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL28875015-2 On May 10, through May 11, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 20, 2023. At the time of the survey, there were 136 residents: 64 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following order was reissued.	{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 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: No further action required.	{0 480}		
{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 repair program. This MN Requirement is not met as evidenced by: No further action required.	{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,	{0 810}		

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{0 810}	Continued From page 2 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	{0 970}		

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{0 970}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required.	{0 970}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	{01060}		

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{01060}	Continued From page 4 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required.	{01060}		
{01620} SS=F	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	{01620}		

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{01620}	Continued From page 5 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: No further action required.	{01620}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (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.	{01650}		

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{01650}	Continued From page 6 This MN Requirement is not met as evidenced by: No further action required.	{01650}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		
{01780} SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that:	{01780}		

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{01780}	Continued From page 7 (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: No further action required.	{01780}		
{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 record review, the licensee failed to ensure medications were safely secured to prevent access from unauthorized personnel for one of two residents (R11) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 May 10, 2023, at 9:45 a.m., the surveyor was	{01880}		

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{01880}	Continued From page 8	{01880}		

greeted by R11 at R11's apartment door. Once entered, R11 was seen walking around the apartment while R11's spouse (R2) was sleeping in their bedroom with the door open. Surveyor observed a locked tan metal box sitting on the kitchen counter. Surveyor then observed a red and white striped kitchen towel near the metal box on the counter that had a bulge. Surveyor lifted the towel and found a red measuring cup with three pills inside it (one large oval white tablet, one half blue and half white capsule, and one pink coated oval tablet).

R11 admitted to licensee on June 2, 2022, with no known drug allergies.

R11 had diagnoses including Alzheimer's Disease, hypertension (high blood pressure), lung nodule, and chronic cough.

R11's Service Plan with an effective date May 10, 2023, indicated R11 received the following services: medication administration, assistance with morning and evening cares, safety checks, and escorts for meals.

R11's Medication Assessment Face to Face dated February 24, 2023, indicated R11 had memory impairment and required assistance with medication administration.

During observation and interview on May 10, 2023, at 10:11 a.m., director of nursing (DON)-A observed the medications left under the kitchen towel and stated they should not have been there. DON-A indicated the licensed practical nurse (LPN) would observe for medications being left out when doing weekly medication set up for R11. DON-A also indicated staff had been trained to notify nursing if they observed medications being

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{01880}	Continued From page 9 left out. DON-A stated he/she checked the apartment frequently initially when the lock box for R2 was started, but recently it was checked occasionally. During interview on May 10, 2023, at approximately 10:20 a.m., unlicensed personnel (ULP)-J stated he/she had not observed medications being left out while in the apartment. The licensee's 7.10 Medication Storage policy dated August 1, 2021, indicated when medications are managed and stored by licensee, medications will be stored in a locked medication box/cabinet in residents' private living spaces to prevent diversion of medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{01880}		
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their	{02170}		

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{02170}	Continued From page 10 activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: No further action required.	{02170}		

Electronically Delivered

April 6, 2023

Licensee
Shoreview Senior Living LLC
4710 Cumberland Street
Shoreview, MN 55126

RE: Project Number(s) SL28875015

Dear Licensee:

On March 17, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on January 12, 2023. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the January 12, 2023 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on January 12, 2023, found not corrected at the time of the March 17, 2023, follow-up evaluation and/or subject to penalty assessment are as follows:

1880-Storage Of Medications-144g.71 Subd. 19 - $3,000.00

The details of the violations noted at the time of this follow-up evaluation completed on March 17, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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.

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Minnesota Department of Health
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85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28875	A. BUILDING: _____ B. WING _____	R 03/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREVIEW SENIOR LIVING LLC	4710 CUMBERLAND STREET SHOREVIEW, MN 55126

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL28875015-1 On March 16, through March 20, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 9, 2023. At the time of the survey, there were 142 residents: 51 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued. On March 20, 2023, the immediacy of correction order 1880 has been removed, however non-compliance remains at a scope and level of G.	{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 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: No further action required.	{0 480}		
{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 repair program. This MN Requirement is not met as evidenced by: No further action required.	{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,	{0 810}		

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{0 810}	Continued From page 2 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	{0 970}		

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{0 970}	Continued From page 3 This MN Requirement is not met as evidenced by: No further action required.	{0 970}		
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and	{01060}		

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{01060}	Continued From page 4 community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: No further action required.	{01060}		
{01620} SS=F	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	{01620}		

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{01620}	Continued From page 5 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: No further action required.	{01620}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (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.	{01650}		

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{01650}	Continued From page 6 This MN Requirement is not met as evidenced by: No further action required.	{01650}		
{01760} SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action required.	{01760}		
{01780} SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that:	{01780}		

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{01780}	Continued From page 7 (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: No further action required.	{01780}		
{01880} SS=G	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were safely secured to prevent access from unauthorized personnel for one of one resident (R11) with medication management services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 16, 2023, at 10:50 a.m., the surveyor was greeted by R11 at R11's apartment door. R11	{01880}		

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{01880}	Continued From page 8	{01880}		

was seen walking around the apartment while the surveyor was speaking with R2 (R11's spouse who shares R11's apartment). The surveyor also noted other residents walking around within the memory care unit.

R11 was admitted to the licensee on June 2, 2022, with diagnoses including Alzheimer's Disease, hypertension (high blood pressure), lung nodule, and chronic cough.

R11's Individualized Services Amendment (ISA) signed on November 4, 2022, indicated R11 received medication assistance by the licensee for morning and nighttime. R11's ISA also indicated medications managed by licensee would be stored to prevent diversion of medications by residents or others who may have access to the medications. R11's ISA indicated medications would be stored in a locked medication box in the resident's private living space.

R11's Medication Assessment Face to Face dated February 24, 2023, indicated R11 had memory impairment and required assistance with administration of medications by the licensee.

On March 16, 2023, at 11:00 a.m., the surveyor spoke with R2 inquiring how she handled her medications. R2 indicated she used to administer all her medications until about a month ago when her family member (FM) started setting up her medications in an automatic timed medi-planner (a locked medication holder that would unlock and allow dispensation of a set dose of medication at a predetermined time). R2 indicated the licensee had "took it [the medi-planner] away from her" this morning. R2 continued to explain how she kept the

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{01880}	Continued From page 9	{01880}		

medi-planner on the kitchen counter with a red towel covering it. R2 stated the medi-planner would flash lights as it unlocked for the dose to be taken at a specific time. R2 stated the medi-planner unlocked at 8:30 a.m., noon, and 7:30 p.m. R2 told surveyor she usually gets up around 9:00 a.m. R2 also explained how she would take one pill from the 7:30 p.m. medications (oxycodone for pain) and put the rest of her prescribed medications in a glass bowl and leave them next to the medi-planner under the red towel and take them when she went to bed around 10:00 p.m. R2 proceeded to show the surveyor a bottle of Xeljanz XR (medication for arthritis) 11 milligrams (mg) in the basket of her two-wheeled walker. R2 explained it was delivered from the pharmacy and R2 had no way to lock up the medication as her FM had the code for the medication box.

On March 16, 2023, at approximately 11:15 a.m., director of nursing (DON)-A indicated the medi-planner was locked with R11's medications in a cabinet and R2 would page staff to unlock the medication cabinet within the room to allow R2 to self-administer her medications. DON-A was unaware R2 had a bottle of Xeljanz XR out in the open as DON-A indicated licensee did not handle R2's medications. DON-A stated R2 exhibited confusion due to medications being out of reach.

On March 16, 2023, at 11:50 a.m., unlicensed personnel (ULP)-J indicated R2's medi-planner had always been locked up and staff would give it to R2 when she paged. ULP-J indicated he/she usually didn't work with R11 as he/she was assigned another part of the unit. ULP-J stated R2 did not show confusion or cognitive decline.

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{01880}	Continued From page 10 On March 16, 2023, at 12:00 p.m., ULP-B stated when he/she worked the evening shift (typically 2:00 p.m. to 10:00 p.m.), he/she would see R2's medi-planner on the counter. ULP-B also stated R2 did not exhibit any memory issues or cognitive decline. On March 16, 2023, at 12:45 p.m., the surveyor interviewed the FM that helped with medi-planner set up. FM indicated the medi-planner started on February 13, 2023, due to concerns with pills missing, so FM sets up the medications once a week and locks up the prescription bottles in a box for which R2 does not have access to. FM indicated there are over the counter medications such as ibuprofen and MiraLax in an unlocked cupboard in R11 and R2's apartment, should R2 need some. FM stated the times scheduled on the medi-planner were 8:30 a.m., 1:00 p.m., and 6:30 p.m. FM indicated R2 did not have any memory issues. The licensee's 7.10 Medication Storage policy dated August 1, 2021, indicated when medications are managed and stored by licensee, medications will be stored in a locked medication box/cabinet in residents' private living spaces. No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by evaluation supervisor review on March 20, 2023, however noncompliance remains at a scope and severity of G.	{01880}		
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	{02170}		

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{02170}	Continued From page 11 (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: No further action required.	{02170}		

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{02170}	Continued From page 12	{02170}		

Electronically Delivered

March 2, 2023

Licensee
Shoreview Senior Living LLC
4710 Cumberland Street
Shoreview, MN 55126

RE: Project Number(s) SL28875015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1880 - 144g.71 Subd. 19 - Storage Of Medications - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

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

Please email 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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jess Schoenecker, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28875	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREVIEW SENIOR LIVING LLC	4710 CUMBERLAND STREET SHOREVIEW, MN 55126

(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#28875015-0 On Janurary 9, through January 12, 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 144 active residents; 58 receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on January 10, 2023, issued for SL28875015-0, tag identification 1880. On January 11, 2023, the immediacy of correction order 1880 has been removed, however non-compliance remains at a scope and level of G.	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 with Dementia Care 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 according to the Minnesota Food Code. This had the potential to affect all 144 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated January 9, 2023. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 2 (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 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). On January 11, 2023, approximately from 11:00 a.m. to 2:35 p.m. survey staff toured the facility with the regional VP of operations (RVPO)-F and the licensed director (LALD)-D. The LALD-D excused himself for a meeting at approximately 12:10 p.m. and rejoined the tour again at approximately 1:20 p.m. During the tour, survey staff observed and the RVPO-F verified the following: 1. In resident room 140, the transition strip from carpet flooring to the bathroom flooring was not secured (loose), creating a potential tripping	0 800		

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0 800	Continued From page 3	0 800		

hazard for residents that shuffled as they walk. The RVPO-F confirmed the finding as he had requested for their maintenance staff to address the strip for repair.
2. The licensee failed to secure chemicals to protect residents from harm:
-In memory care resident room 118, a large bottle of bleach was stored under their kitchen cabinet.
-In memory care resident room 114, room spray chemicals (Behold and Febreeze) were stored under the cabinet.
-In memory care resident room 100, toilet cleaner liquid chemical was stored under the cabinet.
-In memory care resident room 136, carpet cleaner product was stored under the cabinet.
-In memory care resident room 111, toilet cleaner liquid chemical was stored under the cabinet.
3. In memory care resident room 118, a sharp cutting knife (approximately 2-inch wide) was accessible to the resident located inside the kitchen drawer and must be removed. The LALD-D explained this room is double occupancy and the spouse does not have any dementia.
4. In the memory care resident room 140, the oven/stovetop was not disabled or disconnected to prevent the memory care resident from potential harm from misuse. The RVPO-F and the LALD-D confirmed the finding and stated that the resident's son must have visited the resident and turned on the stove/oven by prying the secured breaker panel open.
5. The reduced pressure zone assembly devices located in the garage-level trash rooms and the sprinkler riser rooms were tagged with the last test on each device, dated January 17, 2019. These backflow preventers must be annually tested for proper performance by a qualified backflow tester. The RVPO-F confirmed the findings as he already reached out to their plumbing contractor and scheduled for testing in

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0 800	Continued From page 4 the next two weeks. 6. A"Y" supply fitting with a water control valve feature was improperly hooked up to the hopper sink threaded faucet with an integral vacuum breaker to serve multiple chemical soap dispensers. Survey staff explained to the RVPO-F that the installation was not in compliance with the code to prevent cross-connection of chemicals to the building water supply system since a "Y" fitting connection does not allow for the pressure bleeding device installation. This applies to both installations in the two laundry rooms with the hopper sinks on the first-floor memory care. The RVPO-F consulted with their chemical supplier and agreed with the finding. 7. The installation of the chemical soap dispenser connected to the faucet of the mop sink located inside the commercial kitchen on the first floor lacked a pressure bleeding device to provide for proper cross-connection protection of the building water supply system from contamination. 8. In resident room 325, a toilet attachment handheld bidet hose sprayer was hooked up to the water supply line to the toilet tank without any backflow preventer to prevent cross-connection of contamination to the building water supply system. On January 11, 2023, at approximately 4:00 p.m., during the exit interview, the LALD-D and RVPO-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 5	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and	0 810		

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0 810	Continued From page 6 interview, the licensee failed to provide all required content on the fire safety and evacuation plan, required employee fire and evacuation training, and the required evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 January 11, 2023, at approximately 2:40 p.m., survey staff received and reviewed the fire safety and evacuation documentation, evacuation drill, and training documentation provided by the licensed assisted living director (LALD)-D and the regional VP of operations (RVPO)-F. A documentation review and interview were performed with the LALD-D and RVPO-F at approximately 3:45 p.m. indicating the following: 1. The plan documentation lacked a current building layout plan with the identification of sleeping locations and the number of sleeping rooms for each floor. The finding was evident as the layout only included the stairway exits noted and verified by the LALD-D and RVPO-F as they asked for more details to accurately reflect the identification of sleeping locations for the apartment units. 2. Record review indicated the licensee failed to provide the minimum numbers of fire evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation	0 810		

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0 810	Continued From page 7 drill every other month, a total of a minimum of six drills per year. Drill records received for review were dated with drills performed from July to December of 2022, and no records of drills were provided for the first six months of 2022. 3. Document review indicated that the licensee did not meet the minimum employee fire safety and evacuation training twice per year in addition to new employee orientation. The facility's fire procedure training policy, dated, August 1, 2021, correctly stated the required employee frequency on fire safety and evacuation plan training, but the employee training record provided for review showed one "annual orientation" for employee fire safety training, dated, March 2, 2022. The RVPO-F confirmed the finding and stated that one more needed to be performed for fire safety and evacuation. On January 11, 2023, at approximately 4:00 p.m., during the exit interview, the LALD-D and RVPO-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 9, 2023, at approximately 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-D provided a blank Assisted Living Contract and indicated the contract is used by licensee for all residents who lived in the facility. The licensee's Assisted Living Contract included a section titled 25. Liability and read, "Provider is not liable to Resident for any injury, death or property damage occurring in the Apartment or on Provider's premises." On January 11, 2023, at approximately 1:00 p.m., during the exit conference, LALD-D stated the licensee's assisted living contract included a waiver of liability for health and safety or personal property of the resident. LALD-D stated the liability waiver would need to be removed from all	0 970		

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0 970	Continued From page 9 contracts. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	Continued From page 10 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R10) who had an emergency relocation. 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: R10 was admitted on March 3, 2020. R10's Progress Notes dated November 15, 2022, at 8:46 a.m., indicated R10 had an unwitnessed fall with head injury, was transported to the nearest emergency room for evaluation, and subsequently admitted to the hospital.	01060		

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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
01060	Continued From page 11 R10's Progress Notes dated November 16, 2022, at 2:19 p.m., indicated R10 was discharged back to the facility. R10's record lacked evidence the emergency relocation notice with required content was provided to R10 or R10's designated representative. On January 11, 2023, at approximately 11:00 a.m., regional director of nursing (RDON)-E indicated the licensee had not created an emergency relocation notice with the required content and had failed to provide a notice to any resident who required an emergency relocation. RDON-E stated the licensee would need to develop the notice and provide training on when to utilize the notice. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=F	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	01620		

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	28875	A. BUILDING: _____ B. WING _____	01/13/2023

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01620	Continued From page 12	01620		

and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment to include all areas required on the uniform assessment tool for three of three residents (R3, R5, R7).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R3
R3 admitted on October 13, 2021.

R3's 14/90 Assessment dated December 22, 2022, lacked the required uniform assessment

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01620	Continued From page 13 tool content. R5 R5 admitted on December 26, 2022. R5's RN Evaluation/Face to Face dated December 26, 2022, lacked the required uniform assessment tool content. R7 R7 admitted on May 22, 2013. R7's 14/90 Assessment dated January 2, 2023, lacked the required uniform assessment tool content. R3, R5, and R7's records lacked uniform assessment tool content under Minnesota Rule 4659.0150, subpart 2. The assessments lacked the follow required content: - Personal lifestyle preferences - Physical health status - Emotional and mental health conditions - Cognition - Communication and sensory capabilities - Pain - Risk indicators - Decision making authority - Follow up referrals On January 10, 2023, at approximately 2:00 p.m., regional director of nursing (RDON)-E stated was not familiar with the content of the uniform assessment tool under Minnesota Rule 4659.0150 and indicated the content had not been included for all RN assessments. RDON-E had wondered why they were not informed of this requirement by their outside support advocacy partner.	01620		

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01620	Continued From page 14 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (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:	01650		

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01650	Continued From page 15 Based on interview and record review, the licensee failed to ensure residents' service plans included all required content for three of three residents (R3, R5, R7). 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 January 10, 2023, approximately 10:00 a.m., regional director of nursing (RDON)-E indicated the licensee's Individualized Services Amendment document was the licensee's service plan. R3 admitted on October 13, 2021, and R3's service plan was signed December 12, 2022. R5 admitted on January 4, 2023, and R5's service plan was signed January 4, 2023. R7 admitted on May 22, 2013, and R7's service plan was signed November 4, 2022. R3, R5, and R7's service plan lacked: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff who provided services; and - a contingency plan. On January 11, 2023, at approximately 1:00 p.m., during the exit conference, licensed assisted living director (LALD)-D stated the licensee's	01650		

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01650	Continued From page 16 service plans lacked the required content. LALD-D indicated the licensee included the contingency plan in the licensee's contract but not in the service plan. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated all required content for residents' service plans would be included. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for three of three residents (R3, R5, R7) who received medication management.	01760		

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01760	Continued From page 17 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: R3 R3 was admitted on October 13, 2021. R3's Individualized Services Amendment signed December 12, 2022, identified by regional director of nursing (RDON)-E as R3's current service plan, indicated R3 received medication assist. R3's Medication Administration Record (MAR) for January 2023, identified by RDON-E as documentation the unlicensed personnel (ULP) provided medications to R3, lacked the medication name, dosage, and route of administration. R5 R5 was admitted on December 26, 2022. R5's Individualized Services Amendment signed January 4, 2023, identified by RDON-E as R5's current service plan, indicated R5 received medication assist. R5's MAR for January 2023, identified by RDON as documentation the ULP provided medications to R5, lacked the medication name, dosage, and route of administration.	01760		

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01760	Continued From page 18 R7 R7 was admitted on May 22, 2013. R7's Individualized Services Amendment signed November 4, 2022, identified by RDON-E as R7's current service plan, indicated R7 received Medication Assist. R7's MAR for January 2023, identified by RDON-E as documentation the ULP provided medications to R7, lacked the medication name, dosage, and route of administration. On January 11, 2023, at approximately 9:30 a.m., RDON-E indicated the licensee's MAR lacked the required documentation related to mediation administration per statute. RDON-E stated the licensee's policy was followed, but the licensee's policy lacked the required statutorily required content. Additionally, RDON-E stated the licensee documents medications administration in the same manner for all residents who received medication management administration from an ULPs. The licensee's Medication/Treatment Administration - Documentation policy dated August 1, 2021, lacked identification of the required documentation related to medication administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will	01780		

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01780	Continued From page 19 (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to set up medications by a pharmacy or nurse for a resident having a planned time away one of one resident (R7). 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: R7 was admitted on May 22, 2013. R7's Individualized Services Amendment, identified by regional director of nursing (RDON)-E as R7's service plan, indicated R7 received medication assist every day.	01780		

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01780	Continued From page 20 R7's Medication Sheet dated January 2023, indicated a nurse set up R7's medication in a medication organizer (commonly called a Medi-minder) which included the following: - hydrocodone/acetaminophen (APAP) two times a day (a schedule two controlled medication) - meloxicam one time a day (a nonsteroidal anti-inflammatory drug) - oxycontin three times a day (a schedule two controlled medication) - Seroquel two times a day (an antipsychotic medication) On January 10, 2023, at approximately 8:00 a.m., unlicensed personnel (ULP)-B provided R7 with their morning medications. ULP-B asked R7 if they were going to work that day. R7 indicated they would be working that evening. ULP-B stated to R7 they would pack R7's medications for 1:00 p.m., 5:00 p.m., and 9:00 p.m. ULP-B proceeded to remove the medications from the pre-set-up medication organizer and placed the medications in three separate medication envelopes and labeled the envelopes with the date and times to correspond with the medications administration times. ULP-B placed the envelopes with the medications on the counter and informed R7 their medications were ready for when R7 went to work. On January 10, 2023, at approximately 9:00 a.m., ULP-B stated R7 routinely goes to work and is asked every morning about his work schedule. Additionally, ULP-B stated each time R7 does go to work, the ULPs working that morning would place the evening medications in the envelopes and label them with the date and time of administration for R7 to take with to work. ULP-B stated R7 was provided no other documentation or paperwork with the medications and only the	01780		

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01780	Continued From page 21 envelopes are provided. On January 10, 2023, at approximately 12:20 p.m., RDON-E stated licensee had a nurse set-up medications in the medication containers and was under the impression since a nurse had completed the initial set-up, the ULP could package the medications for R7's planned time away. RDON-E stated the licensee viewed R7's work schedule as unplanned, even when the licensee was aware of the work schedule for the evening the morning of, and when a nurse was present and would be able to set up the time away medications. The licensee's 7.09 Medication Management - Planned & Unplanned Time Away policy dated August 1, 2021, indicated a licensed nurse or pharmacist must set up medications for planned times away. The policy indicated if a ULP does provide medication for times away, the resident would receive information including any special instructions and handling the medication including controlled substances. Additionally, the policy indicated the medication envelopes would be labeled with the resident name, date, and time the medications are schedule. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
01880 SS=G	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	01880		

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01880	Continued From page 22 permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were safely secured to prevent access from unauthorized personnel for one of one resident (R3) with medication management services. This resulted in an immediate order on January 10, 2023, at 12:32 p.m. In addition, the licensee failed to ensure medications were properly stored and labeled for one of two residents (R3) with medication management services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: IMMEDIATE ORDER R3 was admitted on October 13, 2021, with diagnoses including cognitive impairment, forgetfulness, hypertension (high blood pressure), glaucoma, and cellulitis (skin infection). R3's Individual Services Amendment signed on December 12, 2022, indicated R3 required medication assistance for all medications. Under, "Any Client Receiving a Medication Package," read, "Medications managed by the home care provider shall be stored to prevent diversion of medications by clients or others who may have access to the medications."	01880		

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01880	Continued From page 23 R3's Medication Assessment Face to Face record dated January 4, 2023, indicated R3 was forgetful at times with cognitive impairment. R3's controlled substance medication required a double lock. On January 10, 2023, at 8:30 a.m., the surveyor observed R3's room and noted unsecured medications sitting on R3's kitchen table, and side table in the living room. The prescribed and over the counter (OTC) medications kept unsecured on the kitchen table and side table in the living room included: - gabapentin (nerve pain), - levothyroxine (thyroid), - amlodipine (blood pressure), - pain reliever, - famotidine (ulcer), - pravastatin (lowers cholesterol), - hycosyamine (stomach), and - anacin (pain reliever) On January 10, 2023, at 8:30 a.m., unlicensed personnel (ULP)-G indicated the licensee provided medication management to R3, but not to R3's roommate/wife, R4. R4 indicated she manages her own medications and the observed medications listed above belong to her. On January 10, 2023, at 8:45 a.m., surveyor observed ULP-G set up R3's medication and handed them to R3 to self-administer. On January 10, 2023, at 11:26 a.m. director of nursing (DON)-A indicated all residents who received medication management need to have all medications locked up. STORAGE OF MEDICATION R3	01880		

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01880	Continued From page 24 On January 11, 2023, at 10:00 a.m., the surveyor noted R3's locked medication cabinet contained an opened bottle of latanoprost eye drops (for glaucoma), which did not contain an opened date. Surveyor then observed a brand-new box of latanoprost eye drops in the same cabinet. Surveyor asked licensed practical nurse (LPN)-C how long that box had been out of the refrigerator and LPN-C stated when R3 moved into the licensee's memory care unit from the assisted living unit, all the medications were put into the cabinet and LPN-C said the drops were no longer good to use and removed it. The licensee's 7.10 Medication Storage policy dated August 1, 2021, indicated medications will be stored in a locked medication box/cabinet in residents' private living spaces. No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by evaluation supervisor review on January 11, 2023, however noncompliance remains at a scope and severity of G.	01880		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations;	02170		

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02170	Continued From page 25 (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activity plan contained all required content for two of two residents (R3, R5). 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	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28875	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREVIEW SENIOR LIVING LLC	4710 CUMBERLAND STREET SHOREVIEW, MN 55126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02170	Continued From page 26 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: R3 and R5's Resident Activity/History Assessment-13.01 dated October 26, 2022 and December 12, 2022, respectively, lacked assessment of the residents' past interests, current abilities and skills, emotional and social needs and patterns, physical limitations, and identifications of activities for behavioral interventions. On January 10, 2023, at 2:31 p.m., regional director of nursing (RDON)-E acknowledged R3 and R5's assessments lacked the required activities evaluation content. RDON-E stated the licensee was not aware of the required activities evaluation and the required content of the evaluation. RDON-E also indicated the activities director (AD) was responsible for filling out the activity assessment and that AD "was new." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *01/09/23*
Time: 19:00:00
Report: 1031231003

Food and Beverage Establishment Inspection Report

Location:
Shoreview Senior Living Llc
4710 Cumberland Street
Shoreview, MN55126
Ramsey County, 62

Establishment Info:
ID #: 0037498
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512284066
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.

3-200B Food Characteristics:Receiving: temperature, condition
3-202.15 ***** Priority 2 *****

MN Rule 4626.0190 Food packages must be in good condition and must protect the food from adulteration and potential contaminants.

4 CANS OF FOOD PRODUCT HAS EXCESSIVE DENTING ALONG TOP/BOTTOM SEAMS. ***CANS REMOVED FROM SERVICE*** COMPLY WITH ABOVE RULE.

Comply By: 01/09/23

4-100 Equipment Construction Materials
4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

2 SCOOPS AND 1 WISK HAD DAMAGED/UNCLEANABLE AREAS FROM MELT DAMAGE. **UTENSILS DISCARDED.**

Comply By: 01/09/23

4-600 Cleaning Equipment and Utensils
4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

2-DOOR CONVECTION OVEN ON COOK LINE HAS BUILDUP OF BLACK CRUST ON INTERIOR WALLS, DOORS, AND RACKS OF OVEN. CLEAN AND MAINTAIN CLEAN.

Comply By: 01/23/23

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.

INTERIOR OF MICROWAVE HAS SPLATTERS OF FOOD DEBRIS. CLEAN AND MAINTAIN CLEAN.

Comply By: 01/23/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Sanitixre Bucket (cook line)
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Sanitixre Bucket (expo)
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Sanitixre Bucket (prep area)
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: Sanitixre Dispenser
Violation Issued: No

Hot Water: = at 167 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Ambient Air Temp: = at 33 Degrees Fahrenheit
Location: Delfield Undercounter 1-Door Cooler
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking/Cod
Temperature: 207 Degrees Fahrenheit - Location: Fryer Basket
Violation Issued: No

Process/Item: Hot Hold/Ribs
Temperature: 150 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Hot Hold/Cod
Temperature: 165 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Cold Hold/Slaw Cup
Temperature: 44 Degrees Fahrenheit - Location: Delfield Undercounter 1-Door cooler **COOLING**
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Hot Hold/Chili
Temperature: 160 Degrees Fahrenheit - Location: Soup Warmer (expo)
Violation Issued: No

Process/Item: Cold Hold/Juice
Temperature: 40 Degrees Fahrenheit - Location: Superior 1-Door Cooler (expo)
Violation Issued: No

Process/Item: Cold Hold/Meat Sauce
Temperature: 37 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Cold Hold/Deli Ham
Temperature: 36 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

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

Inspection conducted by Chris F (MDH).

All violations discussed with Jeff after inspection.

NOTES:
1. Facility has a full commercial kitchen.
2. Pasteurized eggs are used and on site.
3. No meats served undercooked.
4. Dishwasher and walk-in logs are being kept.

Discussed:
- Illness and illness log
- Handwashing and glove use
- Thermometer use

NOTIFY INSPECTOR OF ADDITIONS OR CHANGES TO THE BUILDING, MAJOR EQUIPMENT ADDITIONS, OR CHANGES OF EQUIPMENT DUE TO A MENU CHANGE. THESE ACTIONS MAY REQUIRE A REMODEL PLAN REVIEW.

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

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Environmental Health inspection report number 1031231003 of 01/09/23.

Certified Food Protection Manager Duane P Sandusky

Certification Number: FM32028 Expires: 12/01/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Duane Sandusky
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031231003

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	2	Date	01/09/23
No. of Repeat RF/PHI Categories Out	0	Time In	19:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Shoreview Senior Living Llc	4710 Cumberland Street	Shoreview, MN	55126	6512284066

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037498		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49	X	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:** 01/09/23

Inspector (Signature)