Electronically Delivered

March 27, 2023

Licensee
Guardian Angels By The Lake
13439 185th Lane Northwest
Elk River, MN 55330

RE: Project Number(s) SL30818015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 28, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. 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

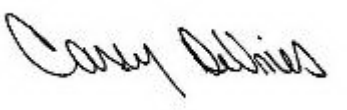
REQUESTING A HEARING

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,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 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
	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(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: SL30818015-0 On February 27 and February 28, 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 85 active residents; 84 of whom received services under the Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for three of four unlicensed personnel (ULP-F, ULP-G, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-F AND ULP-G On February 28, 2023, at 7:24 a.m., the evaluator observed ULP-F and ULP-G apply gloves, transfer R10 to the wheelchair, transfer R10 to the toilet, and remove R10's pants. ULP-F	0 510		

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0 510	Continued From page 2 removed R10's soiled incontinence pull up while R10 was seated on the toilet. Without performing hand hygiene, ULP-F applied a new incontinence pull up and removed gait belt from R10 while ULP-G prepared a washcloth for ULP-F. ULP-F removed R10's shirt, washed R10's breasts and underarms, applied deodorant, applied shirt, and re-applied gait belt to R10. ULP-F and ULP-G stood R10, then ULP-G provided perineal care. Without performing hand hygiene ULP-F and ULP-G completed R10's lower body dressing and removed gloves. Without performing hand hygiene ULP-F applied new gloves, assisted R10 with oral care, and applied makeup to R10 while ULP-G made R10's bed. ULP-F and ULP-G removed gloves and performed hand hygiene. On February 28, 2023, at 8:13 a.m., the evaluator observed ULP-F assist R9 with incontinence pull up removal. Without removing soiled gloves and performing hand hygiene, ULP-F removed R9's shoes, pants, socks, and applied lotion to the lower legs of R9, and removed gloves. Without performing hand hygiene, ULP-F applied gloves and provided perineal care to R9. Without removing soiled gloves and performing hand hygiene, ULP-F raised all clothing items on R9's lower extremities and removed gloves. Without performing hand hygiene, ULP-F applied gloves, completed R9's oral care and grooming, removed gloves, and performed hand hygiene. On February 28, 2023, at 8:35 a.m., ULP-F stated they were trained on infection control during orientation, and they were trained to perform hand hygiene when leaving a room, taking out the trash, and after gloves were removed. In addition, ULP-F stated they did not perform hand hygiene when they removed their gloves with R9 because R9 would walk away while hand hygiene was	0 510		

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0 510	Continued From page 3 being completed and they would not be able to complete care for R9. ULP-H On February 28, 2023, at 8:00 a.m., the evaluator observed ULP-H assist R4 with transfer assistance and ambulation to the dining room table for breakfast. ULP-H did not perform hand hygiene after they assisted R4. On February 28, 2023, at 8:10 a.m., the evaluator observed ULP-H assist R11 with medication administration. ULP-H did not perform hand hygiene before or after the medication administration. On February 28, 2023, at 8:20 a.m., the evaluator observed ULP-H assist R12 with medication administration. ULP-H did not perform hand hygiene before or after the medication administration. On February 28, 2023, at 8:30 a.m., the evaluator asked ULP-H if she had been trained to perform hand hygiene before and after resident cares. ULP-H stated that her training did include performing hand hygiene before and after resident care, and ULP-H proceeded to the sink to wash her hands. On February 28, 2023, at 10:03 a.m., registered nurse (RN)-B stated staff received training for infection control on Relias (a training software program) and all ULP's were certified nursing assistants (CNA) and would have received training on handwashing and infection control during certification. RN-B stated the licensee conducted random hand hygiene audits. In addition, RN-B stated staff were trained to wash their hands with glove removal, upon entrance	0 510		

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0 510	Continued From page 4 and exit of a resident room, before medication was passed, and if gloves became soiled, they should remove the gloves and perform hand hygiene. The Center of Disease Control (CDC) Morbidity and Mortality Weekly Report (MMWR) Guidelines for Hand Hygiene in Health-Care Settings dated October 25, 2002, recommend hand hygiene to be completed before direct contact with patient [residents], moving from a contaminated-body site to a clean-body site during care, and after removing gloves. The licensee's Hand Hygiene / Handwashing - Assisted Living dated February 24, 2023, indicated hand washing would be performed between resident care and whenever direct physical contact with a resident takes place. In addition, hands should be washed or decontaminated before and after contact with a resident, if moving from a contaminated-body site to a clean body-site during resident care, and after removing gloves or gowns. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650		

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0 650	Continued From page 5 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency documentation was maintained for one of three employees (unlicensed personnel (ULP)-F) to include all required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-F was hired on October 1, 2018, under the licensee's former comprehensive license and started providing assisted living services August	0 650		

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0 650	Continued From page 6 1, 2021. ULP-F's record lacked documentation of completed orientation and training for the following topics: - overview of assisted living statutes; - review of provider's policies and procedures; - consumer advocacy services; and - review of types of assisted living services the employee would provide and the provider's scope of license. On February 28, 2023, at 8:35 a.m., ULP-F stated they received orientation and annual training, however, did not remember content received. On February 28, 2023, at 2:17 p.m., registered nurse (RN)-B stated staff completed training on Relias (a training software program) and received trainings and information from Paycor APP (an application that allows employees and managers share information securely from their mobile devices). RN-B stated ULP-F received the content listed above in Paycor however, the licensee lacked documentation of training provided to ULP-F. RN-B provided the evaluator with an undated document titled Minnesota Assisted Living Statues and Rule (Includes Consumer Advocacy) and stated the document listed above all employees received by Paycor which covered the training content listed above. On March 1, 2023, via email correspondence at 8:34 a.m., RN-B stated all employee records lacked documentation of training received on the topics listed above. The licensee's Orientation for Assisted Living with Memory Care Staff dated November 4, 2022, indicated all assisted living employees were	0 650		

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0 650	Continued From page 7 required to complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents and the orientation would include the content listed above. The licensee's Training and Competency Evaluation of Unlicensed Staff dated May 1, 2022, indicated all staff that performed direct services would complete at least eight hours of annual training for each 12 months of employment and the annual training must include a review of the licensee policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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0 780	Continued From page 8 (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms outside and in the immediate vicinity of sleeping rooms in a two bedroom apartment at the facility. This deficient condition had the ability to affect one or a limited number of staff and 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 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 a facility tour on February 28, 2023, at approximately 10:15 a.m. with Licensed Assisted Living Director (LALD)-A, Director of Facilities (DOF)-I, and Maintenance Supervisor (M)-J it was observed that apartment 208 did not have a smoke alarm installed in the common area outside and in the immediate vicinity of the	0 780		

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0 780	Continued From page 9 sleeping rooms. LALD-A, DOF-I, and M-J all visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 800		

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0 800	Continued From page 10 Findings include: On a facility tour on February 28, 2023, at approximately 10:15 a.m. with Licensed Assisted Living Director (LALD)-A, Director of Facilities (DOF)-I, and Maintenance Supervisor (M)-J it was observed that the second-floor trash chute door did not close or latch on its own. The sump pump room in the first-floor memory care unit was obstructed by a full-height bookcase. LALD-A stated the bookcase was mounted to the wall and would need to be removed to fully open the door to the sump pump room. When the survey staff partially opened the door the room had a strong, damp, musty smell. The door could not open enough to see inside the room. LALD-A, DOF-I, and M-J visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(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
01470	Continued From page 11 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

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GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

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01470	Continued From page 12 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing services for one of three employees (unlicensed personnel (ULP-D). 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: ULP-D was hired February 27, 2023, to provide direct care services to residents at the assisted living facility. On February 27, 2023, at 10:30 a.m., the evaluator observed ULP-D providing activities of daily living (ADL's) to residents on the memory care unit. ULP-D's employee records lacked the following required orientation content: - overview of assisted living statutes; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints,	01470		

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(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
01470	Continued From page 13 including information on the Office of Health Facility Complaints; -consumer advocacy services; -review of types of assisted living services the employee will provide and provider's scope of license; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On February 28, 2023, at 2:00 p. m., registered nurse (RN)-B stated ULP-D's employee record lacked all the required orientation content and she was unaware temporary contract staff were required to have the same orientation content as the regular staff. Licensee's Orientation for Assisted Living with Memory Care Staff policy dated November 4, 2022, indicated at minimum, orientation must include the following topics: - An overview of Minnesota's assisted living law - An introduction and review of organizations policies and procedures related to the provision of assisted living services - Emergency and disaster training a. Handling of emergencies and use of emergency services - Principals person centered planning and service delivery and how they apply to direct support services - Types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and provider scope of licensure - Complaint process a. Handling resident complaints b. The facilities system for receiving and responding to complaints, c. Where and how to report complaints	01470		

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

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01470	Continued From page 14 d. Contact information for the Office of Health Facility Complaints e. Contact information for the Office of the Ombudsman for long term care f. Contact information for the Office of the Ombudsman for Mental Health and Disabilities No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered	01730		

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

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01730	Continued From page 15 nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of five residents (R9). 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: R9's diagnoses included Alzheimer's dementia with behavioral disturbance, hypertension, and major depressive disorder.	01730		

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

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01730	Continued From page 16 R9's Service Plan Agreement signed October 15, 2019, indicated R9 resided in memory care and received assistance with laundry, medication administration, incontinence care, and safety checks. R9's Medication Assessment & Management Plan dated December 23, 2022, lacked identification of any specific resident instructions regarding medications the licensee's staff would administer. R9's Medication Administration Record dated February 1, 2023, through February 28, 2023, included lidocaine 5 percent (%) patch, on for 12 hours off for 12 hours, apply 1 patch to affected area once daily for pain. The order lacked specific instructions on where medication was to be applied. On February 28, 2023, from 8:02 a.m. through 8:33 a.m., the evaluator observed ULP-F provide dressing, toileting, grooming, and medication administration to R9. R9 was nonverbal throughout the observation. On February 28, 2023, at 8:13 a.m., the evaluator observed ULP-F apply lidocaine 5 % to R9's lower back. The evaluator inquired how a staff member would know where to apply R9's lidocaine patch. ULP-F stated "sometimes" the electronic medical record (EMAR) indicated where to apply the medication and if the EMAR did not include the instruction, they would have to ask the resident or a coworker where to apply the medication if they did not know where to apply it. On February 28, 2023, at 10:08 a.m., registered nurse (RN)-B stated if a medication had specific	01730		

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(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
01730	Continued From page 17	01730		

instructions, the instructions would be placed on the EMAR. RN-B stated not all topical medications sent from pharmacy included instructions for where to apply the medication and nursing would have to add specific instructions to the EMAR. RN-B stated they were unaware instructions were not added to R9's EMAR. In addition, RN-B stated if an order lacked instructions on where to apply the medication, they trained staff to stop the medication pass and contact a nurse.

The licensee's Medication Management Service policy dated May 1, 2022, indicated following completion of a comprehensive nursing assessment, including and assessment of the resident's need for medication management, the RN would develop an individualized medication management plan for the resident in conjunction with the resident and / or the resident's representative. The plan would address:
- identification of the medication management services to be provided by our facility staff;
- description of how medications managed by our facility will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions (i.e., need for refrigeration);
- identification of any specific resident instructions regarding medications our facility staff will administer;
- identification of the person responsible for monitoring medication supplies and ensuring refills are ordered on a timely basis;
- identification of the staff who are responsible for the medication management tasks, including tasks delegated to unlicensed staff;
- procedure for staff to notify the RN / LPN when there is a problem with any medication management service; and

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

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GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

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01730	Continued From page 18 - any resident-specific requirements relating to documentation of medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for four of four residents (R8, R13, R14, and R15). 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 the residents). The findings include:	01880		

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

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01880	Continued From page 19 On February 28, 2023, at 9:30 a.m., the evaluator observed the medication refrigerator which contained various medications for multiple residents including bisacodyl suppositories (rectal medication) for R8, R13, R14, and R15. The manufacturer's guidelines for bisacodyl suppository dated November 15, 2016, recommended to store it at room temperature and away from excess heat and moisture. On February 28, 2023, at 10:55 a.m., registered nurse (RN)-B stated when suppositories come in from the pharmacy, they always keep them in the fridge. The licensee's Medication Management Services policy dated May 1, 2022, indicated the RN will develop an individualized medication management plan for the resident. The plan will address: -Description of how medications managed by our facility will be stored, based on the resident's needs, risk of diversion and consistent with the manufacturer's directions (i.e., need for refrigeration). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

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01890	Continued From page 20 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of nine residents (R8). 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 February 27, 2023, at 1:08 p.m., the evaluator observed R8's medication cabinet and observed the following expired medication: - nystatin 100,000 units (U)/ gram (gm) with an expiration date of December 2022. On February 27, 2023, at 1:16 p.m., unlicensed personnel (ULP)-E stated they were unaware there was an expired medication in R8's medication cabinet. ULP-E stated they were trained to bring expired medication to the nurse. On February 28, 2023, at 10:09 a.m., registered nurse (RN)-B stated nursing removed expired medication from resident's cabinets with each cycle fill (automatic refilling of routine medications from pharmacy). In addition, RN-B stated if staff noticed an expired medication while they	01890		

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	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 21 performed their three checks for medication administration, they were trained to remove the medication and bring it to a nurse. The licensee's Storage of Medications, Including Controlled Substances dated February 16, 2023, indicated disposal of unused or discontinued prescription drugs managed by licensee would be destroyed by use of Med Safe (medication disposal system). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(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
01910	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition for two of two discharged residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 discharged from the licensee on February 16, 2023. R1's provider orders signed January 11, 2023, included acetaminophen arthritis 650 milligrams (mg), aspirin enteric coat (EC) 81 mg, atorvastatin 10 mg, calcium carbonate with vitamin D 600 mg - 800 international unit (IU), Certavite one tablet, diclofenac sodium 1 percent (%) gel, diltiazem extended release (ER), gabapentin 100 mg, isosorbide ER 15 mg, lisinopril 2.5 mg, mirtazapine 15 mg, polyethylene glycol 17 grams (gm), senexon-s 8.6 mg - 50 mg, tramadol 50 mg, vitamin D3 1000 IU, hydroxyzine hydrochloride (HCL) 25 mg as needed (PRN), and nitroglycerin 0.4 mg prn.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(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
01910	Continued From page 23 The evaluator reviewed R1's Progress notes dated January 18, 2023, through February 17, 2023, and did not observe information regarding disposition of medication. R2 R2 discharged from the licensee on January 19, 2023. R2's provider orders signed October 4, 2022, included acetaminophen 500 mg, amlodipine 5 mg, atorvastatin 10 mg, brimonidine 0.2 % eye drop solution, calcium carbonate 500 mg, clopidogrel 75 mg, erythromycin 0.5 % eye drop solution, furosemide 40 mg, GenTeal Tears eye ointment, hydralazine 10 mg, latanoprost 0.005% eye drop solution, letrozole 2.5 mg, Protonix 40 mg, polyvinyl alcohol 1.4% eye drop solution, PreserVision two capsules, senna 8.6 mg, sertraline 25 mg, vitamin B-12 500 microgram (mcg), and vitamin D3 50 mcg. The evaluator reviewed R2's Progress notes dated December 29, 2022, through January 24, 2023, and did not observe information regarding disposition of medication. R1 and R2's Discharged Assessment dated February 16, 2023, and January 19, 2023, respectively, lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other individuals involved in the disposition. On February 27, 2023, at 11:56 a.m., registered nurse (RN)-B verified R1 and R2's records lacked the content listed above for medication disposition. RN-B stated the licensee	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

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01910	Continued From page 24 documented the required content listed above on narcotics, however, were not consistent with documentation for non-narcotic medications. The licensee's Disposition or Disposal of Medication dated February 28, 2023, indicated unused or discontinued prescription drugs managed by the licensee would be provided to the family or destroyed by two staff with use of Med Safe (medication disposal system). In addition, staff would document the medication's name, quantity, prescription number, persons involved with the destruction of medication, and the date of destruction in the resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 25 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of five residents (R4). 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: R4's diagnoses included diabetes mellitus (high blood glucose levels), diabetic polyneuropathy (weakness and numbness), and acute cystitis (infection of the bladder). R4's service plan dated October 31, 2022,	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 26 indicated R4 received the following services: bathing, grooming, dressing, transfer assistance, housekeeping, meal preparation, laundry services, blood glucose monitoring, and medication administration. R4's Therapy/Treatment Assessment and Management Plan, dated November 18, 2022, indicated R4 had blood glucose monitored daily. R4's Medication Administration Record (MAR) indicated R4's blood glucose readings ranged between 110 milligrams per deciliter (mg/dl) and 361 mg/dl. R4's record lacked the content to include documentation of specific instructions to include blood glucose parameters and procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services. On February 28, 2023, at 2:00 p.m., RN-B stated all residents should have parameters for blood glucose readings and when to notify the nurse. RN-B stated R4's specific instructions had been missed. The licensees Resident Treatment or Therapy Management Plan policy dated, May 1, 2022, indicated following completion of the comprehensive nursing assessment, including an assessment of the resident's need for treatment or therapy management services, the RN develops an Individualized Treatment or Therapy Management Plan for the resident in conjunction with the resident and/or the resident's representative. The plan will address: - Information will also be contained regarding procedure for staff to notify the RN/licensed	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30818	A. BUILDING: _____ B. WING _____	02/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN ANGELS BY THE LAKE	13439 185TH LANE NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 27 practical nurse (LPN) when there is a problem with any treatment or therapy service; - Any resident-specific requirements relating to documentation of treatment or therapy service, verification that all services are performed as prescribed, and monitoring of treatment or therapy use to prevent possible complications or adverse reactions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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

Type: Full
Date: *02/27/23*
Time: 12:22:18
Report: 7989231047

Food and Beverage Establishment Inspection Report

Location:
Guardian Angel by the Lake
13439 185th Lane N.W.
Elk River, MN55330
Sherburne County, 71

Establishment Info:
ID #: 0013565
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Evans Park, Inc., GABTL

Phone #: 7632417682
ID #: 15335

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 165 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Prep Cooler
Temperature: 39 Degrees Fahrenheit - Location: MELON
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: HAM
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: MELON
Violation Issued: No

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit - Location: SOUP
Violation Issued: No

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

Type: Full
Date: *02/27/23*
Time: 12:22:18
Report: 7989231047
Guardian Angel by the Lake

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7989231047 of 02/27/23.

Certified Food Protection Manager: KRISTINA ANDERSON

Certification Number: 28275 Expires: 01/17/25

Signed: _____
Establishment Representative

Signed: Tyffani Maresh

Tyffani Maresh
Public Health Sanitarian
St Cloud
320-223-7361
Tyffani.Maresh@state.mn.us

Report #: 7989231047

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0	Date	02/27/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:22:18
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Guardian Angel by the Lake	13439 185th Lane N.W.	Elk River, MN	55330	7632417682

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0013565	Evans Park, Inc., GABTL	Full		H

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		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		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:** 02/27/23

Inspector (Signature) Tyffani Marcel