Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 18, 2023

Licensee
Amira Choice of Bloomington LLC
5501 American Boulevard West
Bloomington, MN 55437

RE: Project Number(s) SL36899015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 30, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH 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.

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

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

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

The correction order documentation should include the following:

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

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

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

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

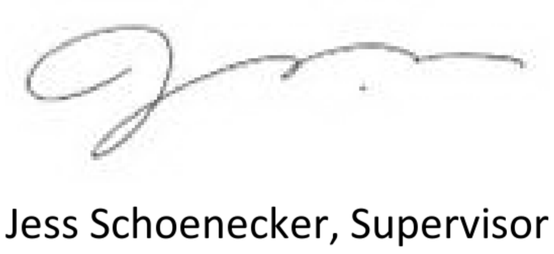
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36899	A. BUILDING: _____ B. WING _____	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE OF BLOOMINGTON LLC	5501 AMERICAN BOULEVARD WEST BLOOMINGTON, MN 55437

(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 the Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#36899015 On June 26, 2023, through June 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 125 active residents; 64 receiving services under the Assisted Living/Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 1 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 680		

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0 680	Continued From page 2 The licensee's EPP dated January 2, 2022, lacked the following required content: - Process for cooperation and collaboration with, regional, State and Federal EP to maintain integrated response; - Subsistence for Staff and Patient for evacuation or sheltering in place; - Procedures for tracking of Staff and Patients; - Policies and Procedures for Volunteers; - Arrangement with other Facilities; - Roles under a Waiver Declared by Secretary; - Primary/Alternate Means of Communication; - Methods for Sharing Information; - Sharing information on Occupancy/Needs; - LTC Family Notification; and - Emergency Prep Testing Requirements. On June 26, 2023, at 11:45 a.m., licensed assisted living director (LALD)-A stated she is not familiar with all of the requirements needed for the disaster plan. LALD-A further stated after looking at the disaster planning resource guidance for 144G, the licensee does not have all of the required content. LALD-A stated she would be working with her regional team to update the disaster plan to include all required content. The licensee's Emergency Preparedness Policy dated August 1, 2021, indicated the emergency preparedness plan included all required elements of appendix Z. The plan was in writing and reviewed annually. The plan was based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan included four primary components: 1. Risk assessment and planning 2. Policies and procedures 3. A communication plan 4. Staff training and exercises/drills licensee	0 680		

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0 680	Continued From page 3 was aware the EPP was lacking content and was working with the regional team to have it updated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=D	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 ability to affect 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) 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).	0 800		

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0 800	Continued From page 4 Findings include: On facility tour with the Licensed Assisted Living Director (LALD)-A between approximately 1:30 PM and 4:30 PM on June 27, 2023, it was observed that the basement trash chute door had a broken/missing fusible link which is required as part of the fire rated shaft assembly. This deficient condition was visually verified by LALD-A accompanying on the tour. Additionally, within the memory care area of the facility, it was observed that potentially dangerous utensils were kept in an unsecured drawer within the kitchen. This deficient condition was visually verified by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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. 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	0 970		

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0 970	Continued From page 5 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 June 26, 2023, at approximately 1:00 p.m., licensed assisted living director (LALD)-A provided a blank Assisted Living Contract and indicated the document was the licensee's assisted living contract signed by all residents who lived in the facility. Additionally, LALD-A provided the licensee's Resident & Family Handbook, and indicated all residents agree to the contents of the guide by signing the Assisted Living Contract. The licensee's Assisted Living Contract undated, on page 16, included a section titled 24. Personal Property and read, "Facility is not responsible for any loss or damage to Resident's personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond Facility's control... In the event Resident's property is damaged or destroyed by fire, efforts to extinguish a fire, or other causes that may be covered by standard fire and extended coverage insurance, or by other insurance coverage, Resident waives: (a) all claims against Facility and its representatives and agents for any such loss or damage; and (b) all rights of subrogation of any insurance company carrying any insurance	0 970		

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0 970	Continued From page 6 covering such loss, damage or destruction." The licensee's Resident & Family Handbook dated August 2023, on page 8, included a section titled Liability and read, "[The licensee] and Management are not responsible for any loss, injury or damages suffered because of the acts of any other Tenant of [the licensee]." On June 26, 2023, at approximately 1:00 p.m., LALD-A acknowledged the licensee's lease agreement and handbook did indicate the licensee was not liable for residents' personal property or damages suffered from the acts of other tenants. LALD-A indicated the language would need to be removed as current language did waive the licensee's liability for the residents' health, safety, and personal property. The licensee's ADM 29.0 Contents of Resident Contract policy dated January 30, 2023, indicated the contract does not include a waiver of facility liability for the health and safety or personal property of a resident. 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	01060		

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01060	Continued From page 7 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 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	01060		

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01060	Continued From page 8 required content for an emergency relocation to the resident, legal representative, or designated representative, for one of one resident (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) 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: R4 was admitted to the licensee on June 1, 2021, for assisted living services. R4's progress note dated January 31, 2023, at 5:30 p.m., indicated R4's daughter was notified of worsening COVID symptoms and post fall generalized weakness. Primary care provider (PCP) notified, and daughter took the resident to the hospital emergency room (ER). R4 progress note dated February 6, 2023, at 4:08 p.m., stated the resident was admitted to the hospital on February 1, 2023, and returned to the facility on February 6, 2023, around 2:20 p.m. R4's records lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. On June 27, 2023, at 12:37 p.m., clinical nurse supervisor (CNS)-B stated they were unaware the licensee needed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative. CNS-B stated they	01060		

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01060	Continued From page 9 call family, but do not provide the written notice. CNS-B further stated if we were to look at all other hospital transfers, we would not find the required documentation. CNS-B also stated licensee was not aware of the need to notify the office of the Ombudsman after a resident is out of the facility for more than four days. The licensee's Emergency Relocation policy updated October 3, 2022, indicated they had a form created for licensee use with all of the required information when a resident is transferred for an emergency relocation. Information required on the licensee's notification of emergency relocation included, resident name, date and place resident transferred, estimated length of stay, right to appeal if resident was not allowed to return to facility, and who had been updated of this emergency relocation. No further information was 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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01620	Continued From page 10 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 monitoring and reassessment no more than 90 days after the previous assessment for three of five residents (R3, R4, 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 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 June 29, 2022. R3's 90-day Assessment was completed on November 2, 2022, with the next assessment due within 90 days or by January 30, 2023. R3's	01620		

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01620	Continued From page 11 record included a 90-day assessment dated April 28, 2023. R4 R4 was admitted on September 30, 2022. R4's 90-day Assessment was completed on October 17, 2022, with the next assessment due within 90 days or by January 15, 2023. R4's record included a 90-day assessment dated February 6, 2023. R4's record also included a subsequent 90-day assessment on May 12, 2023, which was six days past due. R5 R5 was admitted on October 20, 2021. R5's 90-day Assessment was completed on January 12, 2023, with the next assessment due within 90 days or by April 12, 2023. R5's record lacked any subsequent 90-day assessments. On June 27, 2023, at 11:30 a.m., clinical nurse supervisor (CNS)-B indicated the licensee was aware resident assessments were more than 90 days between assessments due to workload and working on catching up with completing assessments within the required timeframes. The licensee's NUR-5.0 Initial and On-Going Nursing Assessment of Residents policy dated October 27, 2021, indicated licensee would complete ongoing resident assessment not to exceed 90 calendar days from the resident's last date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36899	A. BUILDING: _____ B. WING _____	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE OF BLOOMINGTON LLC	5501 AMERICAN BOULEVARD WEST BLOOMINGTON, MN 55437

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880 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 all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for four of six residents (R4, R5, R7, 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) 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: R4 On June 26, 2023, at 7:30 a.m., the surveyor observed Calmoseptine lotion, 70% isopropyl alcohol liquid in a bottle, first aid antiseptic liquid and loperamide 2 milligram (mg) tablets in a box on R4's bathroom counter unlocked and unsecured while accompanying staff and resident back to his room after breakfast. R4's unsigned service plan dated June 27, 2023, indicated R4 received reminders for dressing and grooming in the morning, laundry, weekly shower,	01880		

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	36899	A. BUILDING: _____ B. WING _____	06/30/2023

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01880	Continued From page 13 monthly vitals, bed making every morning, weekly light housekeeping, daily medication administration, two-hour safety checks, and monitoring for bowel movements. R4's Medication Management Plan (MMP) dated October 6, 2022, indicated medications would be securely stored by the licensee in a locked central location only accessible by authorized personnel. R4's Uniform Assessment dated May 12, 2023, indicated R4 does not self-administer any medications. R5 On June 27, 2023, at 8:50 a.m., the surveyor observed Alka Seltzer with 10 pieces in a bottle and mentholated ointment located in R5's bathroom unlocked and unsecured. R5's unsigned service plan dated June 27, 2023, indicated R5 received assistance with emptying garbage cans and tidying room daily, donning and doffing Tubi grip socks (compression stockings), staff assistance with morning dressing and activities of daily living (ADLs), twice weekly laundry, weekly shower, assistance with choosing meals, daily oxygen monitoring, monthly vitals, daily bed making, weekly changing of the sheets, staff administered medications, daily staff escorts to and from meals, overnight repositioning, staff assistance with two person transfer or EZ stand (mechanical lift) transfer, 2 hour safety checks, toileting assistance, monitoring bowel output, and as needed wound care for scratching. R5's MMP dated November 1, 2022, indicated medications would be securely stored by the licensee in a locked central location only accessible by authorized personnel.	01880		

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	36899	A. BUILDING: _____ B. WING _____	06/30/2023

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AMIRA CHOICE OF BLOOMINGTON LLC	5501 AMERICAN BOULEVARD WEST BLOOMINGTON, MN 55437

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01880	Continued From page 14 R5's Uniform Assessment dated January 12, 2023, indicated R5 does not self-administer any medications. R7 On June 27, 2023, at 9:20 a.m., the surveyor observed unlicensed personnel (ULP)-E administer morning medication to R7. While in R7's room surveyor observed moisture barrier cream, Desitin Cream maximum strength, Acetaminophen 500 mg capsules in the bottle, and Asorbin Jr in R7's bathroom unlocked and unsecured. Surveyor also observed Zarbee's cough syrup by the kitchen sink unlocked and unsecured. R7's service plan dated June 28, 2023, indicated R7 received assistance with daily housekeeping, morning cares, evening cares, assistance with transfers with the EZ stand, medication administration, weekly shower, staff escorts to all meals, monthly vitals, daily bed making, floating heels every night, overnight repositioning, two-hour safety checks, monitoring bowel output, assistance with toileting. R7's MMP dated January 9, 2023, indicated medications would be securely stored by the licensee in a locked central location only accessible by authorized personnel. The MMP also indicated the resident does not self-administer any medications. R8 On June 27, 2023, at 9:20 a.m., the surveyor observed ULP-E administer morning medication to R8. While in R8's room the surveyor observed Afrin nasal spray, Systane eye drops, lubricant eye drops, and Nasacort nasal spray on R8's	01880		

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	36899	A. BUILDING: _____ B. WING _____	06/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 15 bathroom counter unlocked and unsecured. R8's service plan signed May 1, 2023, indicated R8 received assistance with morning and evening cares including stand by assist, weekly showers, staff escorts to and from all meals, safety checks, laundry, toileting assistance, and staff assistance with transfers with a gait belt. R8's MMP dated March 27, 2023, indicated medications would be securely stored by the licensee in a locked central location only accessible by authorized personnel. The MMP also indicated the resident does not self-administer any medications. On June 27, 2023, at 9:05 a.m., ULP-E stated staff were not to keep any medications at the bedside in the secured memory care, this includes eye drops and nasal sprays. On June 27, 2023, at 9:15 a.m., licensed assisted living director (LALD)-A stated staff were not to keep any medications at the bedside in the secured memory care including over the counter medications. On June 27, 2023, at 9:45 a.m., clinical nurse specialist (CNS)-B stated no medications were to be kept at the bedside except for creams with a doctor's order. CNS-B further stated they would also need the assessment support to have any medications at the bedside in the secured memory care. CNS-B further stated licensee would look into having locks installed in the bathrooms of the secured memory care to keep the creams secured and locked per medication management plan. The licensee's Medication Storage policy updated	01880		

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01880	Continued From page 16 July 28, 2021, indicated after the medication management plan is completed the RN will identify the need for secure storage because of cognitive status. The RN will identify where the medication will be stored and how they will be locked and stored and who has access to the medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *06/26/23*
Time: 15:38:13
Report: 1018231117

Food and Beverage Establishment Inspection Report

Location:
Cherrywood Pointe Of Bloomingt
5501 American Boulevard West
Bloomington, MN55437
Hennepin County, 27

Establishment Info:
ID #: 0038339
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528351014
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.

No NEW orders were issued during this inspection.

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

FOOD SERVICE FOR THIS ESTABLISHMENT IS CONTRACTED OUT TO A THIRD PARTY VENDOR AND IS COMPLETELY SEPARATE FROM THE ESTABLISHMENT.

FOOD VENDOR IS:

UNIDINE CORPORATION

NO INSPECTION CONDUCTED.

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 1018231117 of 06/26/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed:_____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us