DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 12, 2022

Administrator
Pheasants Ridge
1807 Sunrise Drive
Saint Peter, MN 56082

RE: Project Number(s) SL30532015

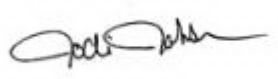
Dear Administrator:

On November 21, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 15, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
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St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

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Electronically Delivered

October 14, 2022

Administrator
Pheasants Ridge
1807 Sunrise Drive
Saint Peter, MN 56082

RE: Project Number(s) SL30532015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 15, 2022, 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.

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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should be addressed 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. 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,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30532	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANTS RIDGE	1807 SUNRISE DRIVE SAINT PETER, MN 56082

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30532015 On September 12, 2022, through September 15, 2022, 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 24 residents; all of whom were receiving services under the provider's Assisted Living license. On September 15, 2022, the immediacy of correction order 1290 was removed; however, non-compliance remains at a scope and level of I (level 3, widespread).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2 and 3.	
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the staff posting included all the required elements, potentially affecting all the licensee's current residents, staff, and visitors. 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	0 470		

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0 470	Continued From page 2 or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings included: During the entrance conference on September 12, 2022, at 10:55 a.m. director of nursing (DON)-B confirmed working scheduled hours Monday thru Friday from 8:00 a.m. until 4:00 p.m. On September 12, 2022, at 12:07 p.m. the staff posting was observed written on a whiteboard outside of the dining area near the front entrance. The posting indicated the first name of the unlicensed staff working on the day, evening, and night shift. The posting also indicated which part of the building each staff was working at. The posting did not indicate the specific hours of each shift nor did it indicate that a nurse was also working direct care in the building. On September 13, 2022, at 2:30 p.m. DON-B confirmed the staffing schedule did not identify the specific times for each shift and also did not include the DON in the staffing hours. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule dated August 1, 2021, indicated: 6. The clinical nurse supervisor, or designee, will develop a 24-hour daily staffing schedule. 7. The 24-hour daily staffing schedule will include: a. Direct-care staff work schedules for each direct-care staff member. b. Indication of all work shifts, including days and hours worked. c. Identify direct-care staff member's resident assignments or work location. 8. The daily work schedule will be posted at the beginning of each shift.	0 470		

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0 470	Continued From page 3 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

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0 480	Continued From page 4 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 13, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had	0 550		

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0 550	Continued From page 5 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 12, 2022, at 12:07 p.m. the surveyor toured the facility with licensed assisted living director (LALD)-A. There was no evidence the grievance procedure or contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities was posted in a conspicuous place. LALD-A confirmed the above content was not posted. The licensee's Complaint Policy and Procedure dated August 1, 2021, indicated each resident or resident representative receives written notice of our facility's process for receiving and resolving complaints. The policy did not include verbiage related to posting the information in a conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		

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0 640	Continued From page 6	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number as required. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 12, 2022, at 12:07 p.m. the facility	0 640		

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0 640	Continued From page 7 was observed to be lacking posting of the MAARC hotline in the common areas of the facility. Licensed assistant living director (LALD)-A confirmed the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a TB symptom screen and two-step TST (tuberculin skin test) or other	0 660		

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0 660	Continued From page 8 evidence of TB screening such as a blood test, for one of three employees (unlicensed personnel (ULP)-D). In addition, the licensee failed to ensure TB training was completed for two of two employees (ULP-C, 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: The licensee's TB facility risk assessment dated July 15, 2022, indicated the licensee was a low risk. ULP-C's employee record indicated a start date of September 24, 2020. ULP-C's record lacked evidence of TB training upon hire and annually. On September 15, 2022, at 9:45 a.m. director of nursing (DON)-B confirmed ULP-C's record did not include the required training. ULP-D's employee record indicated a start date of August 10, 2022. ULP-D's employee record did not contain the following: - documentation of a completed health history and symptom screening; - completion of a two-step TST or other evidence of TB screening such as a blood test; and - documentation related to TB training On September 15, 2022, at approximately 10:00	0 660		

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0 660	Continued From page 9 a.m. DON-B confirmed ULP-D's record did not include evidence a TB symptom screen or a two-step TST had been completed upon hire. DON-B further confirmed ULP-D had not completed the required TB training. The licensee's TB Prevention and Control policy revised July 15, 2022, indicated upon hire all staff will be screened for TB symptoms and tested for TB. Staff will not work in resident care areas or areas where there is potential contact or shared space with residents until TB testing and screening is completed and a negative TB test is provided. The policy further indicated staff are educated on basic infection control including foodborne pathogens upon hire and annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 10 (5) have a written policy and procedure regarding missing tenant 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 develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on September 12, 2022, at 10:55 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor.	0 680		

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	30532	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANTS RIDGE	1807 SUNRISE DRIVE SAINT PETER, MN 56082

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0 680	Continued From page 11 The licensee's plan lacked an all-hazards vulnerability assessment in addition to the following required content: - a description of the population served by the licensee; - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - development of policies/procedures to address: - evacuation plan; - shelter in place; - the medical record documentation system to preserve resident information; - use of volunteers; - emergency staff strategies; and - the facility's role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for resident physicians; - contact information for federal, state, tribal, local EP staff, or the ombudsman; - primary and alternative means for communicating with facility staff, or federal, state, regional and local - policies and procedures to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act -emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the	0 680		

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0 680	Continued From page 12 emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On September 15, 2022, at 11:30 a.m. licensed assistant living director (LALD)-A confirmed the provided Emergency Plan did not contain all the required components and further stated having no knowledge of Appendix Z and it's requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one resident's (R5) personal health and medical information was kept private. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 700		

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0 700	Continued From page 13 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5's diagnoses included macular degeneration (a common eye disorder that causes central vision loss). On September 13, 2022, at 8:15 a.m. the surveyor observed a bulletin board above the medication cart on the assisted living side of the building. The bulletin board included and 8 1/2 x 11 size paper tacked on the board with R5's first and last name and "eye drop schedule" at the top of the page. The remainder of the page had R5's eye drop orders listed with the times of administration. This information was posted in an open public area that residents, staff, and visitors were observed to use often. On September 13, 2022, at 2:30 p.m. director of nursing (DON)-B confirmed the eye drop schedule with R5's name on it was posted on the bulletin board with his name visible and confirmed this was a HIPAA (Health Insurance Portability and Accountability Act of 1996 is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge) violation. DON-B immediately removed the form and placed it on a clipboard on the med cart with other important papers for the staff when they pass medications. The licensee's Security of Resident Records	0 700		

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0 700	Continued From page 14 policy dated November 17, 2021, indicated resident records will be kept secure and protected against loss, tampering or unauthorized disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to	0 730		

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0 730	Continued From page 15 the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged 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, 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 record lacked a discharge summary to	0 730		

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0 730	Continued From page 16 include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R4 was admitted to the licensee on February 17, 2022, with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs). R4's record/progress notes did not include information related to discharge. On September 13, 2022, at 12:10 p.m. licensed assisted living director (LALD)-A stated R4 was at the facility for a short time, had a change in condition and was hospitalized. R4 subsequently went to a skilled nursing facility (SNF) for therapy prior to returning to the assisted living facility (ALF). R4 did not progress to the point where he could return to the facility. R4 and family decided he would remain at the SNF and was formally discharged from the ALF on April 25, 2022. LALD-A confirmed a discharge summary had not been completed. On September 15, 2022, at 11:25 a.m. director of nursing (DON)-B confirmed having knowledge of the criteria needed for a discharge summary, but was off during the time R4 discharged from the facility.	0 730		

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0 730	Continued From page 17 The licensee's Discharge Summary policy dated November 17, 2021, indicated: 1. A discharge summary will be written by the time of discharge. 2. Organization will provide resident a written discharge summary at the time of discharge. 3. If the resident consents, the organization will provide the resident's representative and case manager a written discharge summary at the time of discharge. 4. The discharge summary will include, if applicable, a. Summary of the resident's stay, including i. Diagnosis ii. Courses of illnesses iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab results vii. Pertinent radiology results viii. Pertinent consultation results ix. Final summary of the resident's status. The summary will be based upon the latest assessment or review and, if applicable, will include resident status including baseline and current mental, behavioral, and functional status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
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	0 800		

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0 800	Continued From page 18 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). Findings include: On a facility tour on September 13, 2022, at approximately 11:00 a.m. with Licensed Assisted Living Director (LALD)-A it was observed that the emergency lighting for the exit corridors were not operational upon testing. LALD-A visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 19 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee and resident	0 810		

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0 810	Continued From page 20 training on fire safety and evacuation. This 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). Findings include: A record review and interview were conducted on September 13, 2022, at approximately 10:15 a.m. with Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did include procedures for resident movement, evacuation, or relocation during a fire or similar emergency but did not include the identification of unique or unusual resident needs for movement or evacuation. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, LALD-A stated that the facility did not have documentation or a policy on employee training of the fire safety and evacuation plan.	0 810		

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0 810	Continued From page 21 Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, LALD-A stated that the facility did not have documentation or a policy on resident training of the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that drills were only conducted on 2/17/22 and 7/12/22 and did not specify which shift number or made and had no provisions for evacuation procedures included in the drill. During interview, LALD-A verified that these were the only drills conducted and that there were no further documented drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced	0 970		

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0 970	Continued From page 22 by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. -Page 16, section 31 of the contract indicated "The Community is not liable to the Resident or Resident's guests for any injury, death or property damage occurring in the Apartment or the Community premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests. The Community is also not liable for any injury, death or damage occurring as the result of the Resident's receipt of health-related, supportive, or other services from the third-party providers. The Community may be liable to Resident for its own negligent acts or those of its employees or agents. Unless caused by one of the aforementioned excepted reasons. Resident agrees to hold Community harmless from any and all claims for injuries, property	0 970		

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0 970	Continued From page 23 damage or any other loss resulting from an accident or other occurrence in the Apartment or on the Community premises." On September 13, 2022, at 3:18 p.m. licensed assisted living director (LALD)-A verified the licensee's contract included the above content, and stated the same contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was completed prior to staff providing services, for	01290		

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01290	Continued From page 24	01290		

one of two employees (unlicensed personnel (ULP)-D) with records reviewed. This had the potential to affect all residents living in the facility. This resulted in an immediate correction order on September 15, 2022, at approximately 9:30 a.m.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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:

ULP-D was hired to provide assisted living with dementia care services for the licensee on June 10, 2022.

The licensee lacked evidence a background study had been completed prior to ULP-D providing direct care and services to residents.

On September 15, 2022, at approximately 9:30 a.m. human resources director (HRD)-E verified there was not a background study clearance in ULP-D's employee file. HRD-E stated ULP-D has been informed of the need to complete fingerprinting for the background study. HRD-E further stated they allowed ULP-D to work due to staff shortage. HRD-E verified ULP-D worked independently with assisted living residents and in the memory care unit without direct supervision.

The licensee's Background Checks policy dated August 1, 2021, identified all employees, contractors, and regularly scheduled volunteers

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01290	Continued From page 25 of the facility with direct resident contact must pass a background study. "Direct contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program. Only those with satisfactory results will continue to work with the facility and it's residents. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On September 15, 2022, the immediacy was removed as confirmed by email correspondence with evaluation supervisor, but non-compliance remains. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices;	01370		

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01370	Continued From page 26 (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations of unlicensed personnel (ULP) providing assisted living services were conducted by a registered nurse (RN) for two of two unlicensed personnel (ULP-C and 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	01370		

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01370	Continued From page 27 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C began providing direct care services for the licensee on August 1, 2021, under the assisted living licensure. ULP-C's employee record lacked evidence the employee had been trained by a RN in the following areas: - basic infection control including blood-borne pathogens; - medication, exercise, and treatment reminders; and - preparation of modified diets as ordered by a licensed health professional; On September 15, 2022, at 9:45 a.m. director of nursing (DON)-B confirmed ULP-C's record did not include the above required training. ULP-D began providing direct care services for the licensee on August 10, 2022. ULP-D's employee record lacked evidence the employee had been trained by a RN in the following areas: - maintenance of a clean and safe environment; - medication, exercise, and treatment reminders; - awareness of confidentiality and privacy; and - understanding appropriate boundaries between staff and clients and the client's family On September 15, 2022, at approximately 10:00 a.m. DON-B confirmed ULP-D's record did not include the above required training. The licensee's Staff Orientation policy, dated August 1, 2021, indicated newly hired staff will receive orientation and training on topics required	01370		

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01370	Continued From page 28 for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	01530		

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01530	Continued From page 29 Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame. 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: The licensee provided services under an Assisted Living with Dementia Care license. ULP-D was hired on June 10, 2022, to provide direct care services to the licensee's residents ULP-D's employee record contained evidence the employee received four hours and 45 minutes of dementia care training, not the required eight hours of training within 160 working hours of the employment start date. On September 15, 2022, at 10:00 a.m. director of nursing (DON)-B confirmed ULP-D had not completed the required eight hours of dementia training within 160 hours of the employment start date. The licensee's Staff Orientation policy dated August 1, 2021, indicated newly hired staff will receive orientation and training on topics required	01530		

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01530	Continued From page 30 for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the	01620		

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01620	Continued From page 31	01620		

registered nurse (RN) completed a resident assessment within 14 days of admission for one of one resident (R3) and ongoing resident reassessments that did not exceed 90 days for two of three residents (R3, R2).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3
R3 began receiving assisted living with dementia care services on January 24, 2022.

R3's Service Plan signed February 9, 2022, indicated R3 received services for toileting assist, dressing, grooming, bathing, housekeeping, laundry and medication administration.

On September 13, 2022, at 9:05 a.m. the surveyor observed unlicensed personnel (ULP)-F administering R3's scheduled medications to the resident.

R3's record indicated the RN completed a 14-day assessment on February 9, 2022, (16 days after start of services-two days late). The RN then completed another assessment on February 11, 2022. The next 90-day assessment was completed by the RN on May 17, 2022 (five days

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01620	Continued From page 32 late). R2 R2's service plan dated September 1, 2022, indicated R2 received services including ostomy care, dressing, bathing, housekeeping, laundry and medication administration. On September 13, 2022, at 12:00 p.m. R2 was observed in the assisted living dining room eating lunch. R2's record indicated the RN completed a reassessment on June 9, 2022, and on September 7, 2022, which indicated 95 days passed between assessments. On September 15, 2022, at 11:25 a.m. director of nursing (DON)-B confirmed a reassessment must be completed within 14 days of start of services and a minimum of every 90 days thereafter. DON-B stated she receives an alert on the computer when assessments are coming due, but had been off during the time of R3 and R2's assessment indicated above. The licensee's Attachment D - Individual Service Plan dated August 1, 2021, indicated clients are assessed upon admission, and all services are reviewed 14 days after initiation of services and at least every 90 days thereafter. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 33 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to finalize a current written service plan within 14 calendar days for one of one resident (R3) with records reviewed. 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	01640		

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01640	Continued From page 34 situation has occurred only occasionally). The findings include: R3's record indicated R3's start of services date was January 24, 2022. R3's diagnoses included dementia and diabetes. R3's Care Plan (which is part of the Service Plan) dated January 24, 2022, indicated R3 received services for toileting assist, dressing, grooming, bathing, housekeeping, laundry and medication administration. R3's Attachment D - Individual Service Plan was not signed until February 9, 2022. The service plan failed to be finalized no later than 14 days after services were first provided on January 24, 2022. On September 15, 2022, at 11:25 a.m. director of nursing (DON)-B confirmed resident service plans must be signed within 14 days of start of services. The licensee's Content of Service Plans policy dated August 1, 2021, indicated a finalized service plan will be completed no later than 14 calendar days after initiation of services. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services	01700		

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01700	Continued From page 35 (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for three of three residents (R1, R2, R3), prior to providing medication management services. This practice resulted in a level two violation (a	01700		

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01700	Continued From page 36 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on September 12, 2022, at approximately 10:55 a.m. director of nursing (DON)-B confirmed the licensee provided medication management services to all of the residents receiving assisted living services. R1 R1 was admitted on August 25, 2020, and began receiving assisted living services from the licensee on August 1, 2021. R1's diagnoses included type II diabetes mellitus, chronic obstructive pulmonary disease (COPD-a chronic inflammatory lung disease that causes obstructed airflow from the lungs) hypertension (high blood pressure), depression, and hypercholesterolemia (high cholesterol). R1's Service Plan Agreement October 9, 2021, indicated R1 received services including medication administration. R1's prescriber orders signed August 22, 2022, included the following medications: one antidepressant, one antihypertensive, one insulin injectable, one diuretic, one antihyperlipidemic, and one inhaler for COPD.	01700		

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01700	Continued From page 37 On September 13, 2022, at 8:22 a.m. the surveyor observed unlicensed personnel (ULP)-C administering R1's scheduled injectable insulin, diuretic, antidepressant, antihypertensive, and inhaler to the resident. R1's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R2 R2 was admitted to the facility on May 16, 2011, and began receiving assisted living services from the licensee on August 1, 2021. R2's diagnoses included type II diabetes mellitus, hypertension, hyperlipidemia (high cholesterol) and epilepsy. R2's Service Plan Agreement dated September 1, 2022, indicated R2 received services including medication administration. R2's prescriber orders signed August 22, 2022, included the following medications: three antihypertensives, one insulin response enhancer for diabetes, one antihyperlipidemic, and two anticonvulsants for epilepsy. R2's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R3 R3 began receiving assisted living services from the licensee on January 24, 2022.	01700		

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01700	Continued From page 38 R3's diagnoses included dementia, type II diabetes mellitus, hyperlipidemia, cerebrovascular disease, edema, and anxiety. R3's Service Plan Agreement dated February 9, 2022, indicated R1 received services, which included medication administration. R3's prescriber orders signed August 23, 2022, included the following medications: one insulin response enhancer for diabetes, one antihyperlipidemic, one diuretic, and two antidepressants. On September 13, 2022, at 9:05 a.m. the surveyor observed ULP-F administering R3's scheduled diuretic and one of R3's antidepressants to the resident. R3's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On September 13, 2022, at 9:05 a.m. director of nursing (DON)-B confirmed R1, R2, and R3 have received medication administration services since their admission dates. DON-B further confirmed a face-to-face medication assessment including all the required content had not been completed for R1, R2, or R3. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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01790	Continued From page 39	01790		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in	01790		

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	30532	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANTS RIDGE	1807 SUNRISE DRIVE SAINT PETER, MN 56082

(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
01790	Continued From page 40 the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for the unlicensed personnel (ULP) providing medications for residents with unplanned time away from home when the licensed nurse was not available for two of two unlicensed personnel (ULP-C, ULP-D) reviewed. 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	01790		

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01790	Continued From page 41 only occasionally). The findings included: ULP-C and ULP-D were hired to provide direct care to the licensee's residents on April 1, 2021, and August 10, 2021, respectively. ULP-C and ULP-D's employee records lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On September 15, 2022, at 11:18 a.m. director of nursing (DON)-B confirmed ULP-C and ULP-D were trained to administer medications. DON-B further confirmed she goes over the procedure and demonstrated to the ULP how to prepare medications for residents with unplanned time away. DON-B reviewed ULP-C and ULP-D's employee record and confirmed there was no documentation of training and competency regarding preparing medications for residents with unplanned time away. The licensee's Delegation of Medications To be Given By Unlicensed Staff For Clients Time Away From Home policy dated November 17, 2021, indicated the agency will provide the necessary medications, education, instructions and support to meet the client's medication needs when they are away from home if the agency provides assistance with self-administration of medication, administration, administration or storage of medications. Only unlicensed staff that have been trained and have satisfactorily demonstrated competency will be assigned to place medications prepared by a pharmacist or a	01790		

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	30532	A. BUILDING: _____ B. WING _____	09/15/2022

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01790	Continued From page 42 licensed nurse in the appropriate container for an unplanned leave of absence not to exceed seven days of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of one resident (R1) with insulin. 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:	01890		

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01890	Continued From page 43 R1 had diagnoses including type II diabetes mellitus. R1's physician orders signed August 23, 2022, included an order for Victoza (a non-insulin medication used to lower blood sugar) 18 mg (milligrams)/3 ml (milliliter) subcutaneous solution pen-injector. Inject 1.8 mg subcutaneously (under the skin) twice daily. On September 13, 2022, at 8:22 a.m. unlicensed personnel (ULP)-C was observed setting up R1's medication for administration which included the Victoza injectable pen. The pen was not labeled with an opened or expired dated. ULP-C confirmed the Victoza pen had not been labeled with the date opened and further confirmed the pen had previously been used. ULP-C proceeded to administer R1's medications including the Victoza. On September 13, 2022, at 2:30 p.m. director of nursing (DON)-B observed R1's opened Victoza pen with the surveyor and confirmed the date opened should have been written on the pen and wasn't. DON-B stated staff were trained to always fill in the date opened when opening a new insulin pen, and further stated there was a reminder in the MAR (medication administration record) as well. The Victoza liraglutide injection 1.2 mg/1.8 mg package insert dated July 2022, indicated to use a Victoza pen for only 30 days. Throw away a used Victoza pen after you start using it, even if some medicine is left in the pen. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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01890	Continued From page 44 days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). Findings include:	02040		

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02040	Continued From page 45 A record review and interview were conducted on September 13, 2022, at approximately 10:15 a.m. with Licensed Assisted Living Director (LALD)-A on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A verified that the licensee had not conducted a hazard vulnerability assessment for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects	02110		

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02110	Continued From page 46 of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the resident's legal and designated representative at the time of move-in for three of three residents (R1, R2, R3). 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 included: The licensee was licensed as an Assisted Living	02110		

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02110	Continued From page 47 with Dementia Care facility on August 1, 2021. R1, R2, and R3's records lacked documentation for receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On September 13, 2022, at 3:18 p.m. licensed assisted living director (LALD)-A stated all residents/legal representatives and/or designated representative received a Disclosure Statement for Special Care Units which touched on some of the above topics. LALD-A confirmed the licensee did not provide written dementia care policies and	02110		

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02110	Continued From page 48 procedures at time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of	02240		

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02240	Continued From page 49 Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for two of three residents (R1, R3). 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: The facility converted to an Assisted Living license on August 1, 2021. R1 began receiving assisted living services on August 1, 2021.	02240		

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02240	Continued From page 50 On September 13, 2022, at 8:22 a.m. unlicensed personnel (ULP-C) was observed administering medications to R1. R3 began receiving assisted living services on January 24, 2022. On September 13, 2022, at 9:05 a.m. ULP-F was observed administering medications to R3. R1 and R3's records lacked evidence the residents received the Assisted Living Bill of Rights dated May 16, 2021, or August 12, 2022. On September 13, 2022, at 12:10 p.m. licensed assisted living director (LALD)-A stated all residents received the updated Assisted Living Bill of Rights dated May 16, 2021, prior to the newest one that came out, but he didn't have them sign they received it. LALD-A further confirmed the newest Bill of Rights dated August 12, 2022, was given to residents during their annual review or with new admissions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities."	03090		

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03090	Continued From page 51 (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents, staff and any visitors of the facility. This practice resulted in a level one violation (a violation that has not 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 finding include: On September 12, 2022, at approximately 10:30 a.m. upon arriving at the establishment, an observation outside the front entrance, or just inside the front entrance, lacked the required posting for electronic monitoring devices. On September 12, 2022, at 12:07 p.m. licensed assisted living director (LALD)-A confirmed there were cameras in the common area of the assisted living and memory care portions of the building. LALD-A further confirmed no posting was available related to the statutory language for electronic monitoring. No further information was provided.	03090		

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03090	Continued From page 52 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *09/13/22*
Time: 11:10:09
Report: 1020221110

Food and Beverage Establishment Inspection Report

Location:
Pheasants Ridge
1807 Sunrise Drive
St Peter, MN56082
Nicollet County, 52

Establishment Info:
ID #: 0038447
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5079310966
ID #:

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

The following orders were issued during this inspection.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

WOODEN SHELVING USED FOR DRY STORAGE IS UNSEALED; SEAL THE WOOD WITH COMMERCIAL PAINT TO ENSURE THE SURFACE IS EASILY WIPEABLE AND CLEANABLE.

Comply By: 10/31/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Wash Temperature Gauge: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Final Rinse Temperature Ga: = at 190 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Utensil Surface Temperatur: = at 165 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: CHEESE - UPRIGHT COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 206 Degrees Fahrenheit - Location: CHICKEN - STEAM TABLE
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - CHEST FREEZER, STORAGE ROOM

Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER, STORAGE ROOM

Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - WHITE UPRIGHT FREEZER, STORAGE ROOM
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - UPRIGHT COOLER, STORAGE ROOM
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: DOUGH - UPRIGHT COOLER, STORAGE ROOM
Violation Issued: No

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

GENERAL COMMENTS:

DISCUSSED EMPLOYEE ILLNESS POLICIES AND PROCEDURES. AN EMPLOYEE ILLNESS LOG IS USED ON-SITE. AN EMPLOYEE ILLNESS POLICY IS IN PLACE AND IS SIGNED BY EACH STAFF MEMBER AT THE FACILITY.

ALL FOOD IS PREPARED ON-SITE. LEFT OVER FOOD ITEMS ARE COOLED IN A SHALLOW CONTAINER AND PLACED INTO THE UPRIGHT COOLER. LEFT OVER FOOD ITEMS ARE SAVED FOR NO MORE THAN TWO DAYS. ANY RE-HEATED FOOD ITEMS ARE FOR IMMEDIATE SERVICE.
CART WITH A WARMER IS USED TO TRANSFER FOOD ITEMS TO MEMORY CARE AREA FOR IMMEDIATE, SAME DAY SERVICE.

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 1020221110 of 09/13/22.

Certified Food Protection Manager: DAnielle J. Rose

Certification Number: FM100628 Expires: 09/11/25

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley B
Ashley B

651-201-4500

Report #: 1020221110

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0	Date	09/13/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:10:09
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Pheasants Ridge	1807 Sunrise Drive	St Peter, MN	56082	5079310966

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038447		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		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	X	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) Report emailed **Date:** 09/22/22

Inspector (Signature)