Electronically Delivered
January 26, 2022

Administrator
The Encore At Maplewood
2300 Hazelwood Street
Maplewood, MN 55109

RE: Project Number(s) SL30614015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 17, 2021, 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, no immediate fines are assessed.

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 surveys. 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.

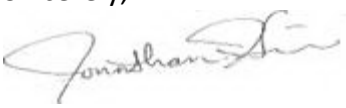
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. 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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
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Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 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
	30614	A. BUILDING: _____ B. WING _____	12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT MAPLEWOOD	2300 HAZELWOOD STREET MAPLEWOOD, MN 55109

(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 a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL306140015-0 On December 15, 2021 through December 17, 2021, 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 27 residents receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
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 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food	0 480		

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0 480	Continued From page 2 and Beverage Establishment Inspection Report, dated December 15, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 27 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	0 640		

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0 640	Continued From page 3 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked the following: - post the 911 emergency number in common areas and near telephones provided by the assisted living facility - post information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557 On December 15, 2021, at approximately 11:30 a.m., during a facility tour, the surveyor observed no postings in the facility with the required MAARC or 911 contact information. On December 15, 2021, at approximately 12:30 p.m. regional director of wellness (RDOW)-F confirmed the required content noted above had not been posted as required. The licensee's Vulnerable Adult Maltreatment - Prevention and Reporting policy dated July 1, 2021, indicated the licensee would post information and reporting number for the Minnesota Adult Abuse Reporting Center (MAARC). The policy also indicated the licensee would post the 911 emergency number in common areas and near telephones provided by the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 640		

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0 640	Continued From page 4 days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on record review and interview, the	0 650		

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0 650	Continued From page 5 licensee failed to ensure employee records included the required content for two of two employees (unlicensed personnel (ULP)-A, ULP-B) with employee 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 situation has occurred only occasionally). The findings include: ULP-A was hired by the licensee on April 16, 2021, to provide direct care to the licensee's residents. On December 17, 2021, at 10:00 a.m. ULP-A's employee records lacked evidence of a job description. ULP-B was hired by the licensee on August 24, 2021, to provide direct care to the licensee's residents. On December 17, 2021, at 10:30 a.m., ULP-B's employee records lacked evidence of a job description. On December 17, 2021, at approximately 1:30 p.m. the regional vice president of operations (RVPO)-G verified ULP-A and ULP-B's employee records lacked evidence of a job description The licensee's Organization of Personnel [employee] Records policy dated July 1, 2021, indicated employee records must include a	0 650		

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0 650	Continued From page 6 signed job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of two employees (unlicensed personnel	0 660		

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0 660	Continued From page 7 (ULP)-A), and training for two of two employees (ULP-A, ULP-B) with employee 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-A was hired by the licensee on April 16, 2021, to provide direct care to the licensee's residents. ULP-A's employee records lacked evidence of baseline TB history and symptom screenings and screenings for active TB with either a two-step TST or blood test and TB training. On December 17, 2021, at approximately 1:30 p.m., licensed assisted living director (LALD)-C verified ULP-A's employee record lacked evidence of TB screening and TB training. LALD-C reported she had been keeping track of employee TB testing on an Excel spreadsheet on her computer. The surveyor requested the Excel spreadsheet to review dates of employees' TB testing. LALD-C had not provided Excel document of by end of survey. ULP-B was hired by the licensee on August 24, 2021, to provide direct care to the licensee's residents. ULP-B's employee record lacked evidence of TB training	0 660		

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0 660	Continued From page 8 On December 17, 2021 at approximately 1:30 p.m., LALD-C verified ULP-B's employee records lacked evidence of TB training. The licensee's MN Staff TB Testing policy dated April 1, 2020, indicated the licensee would establish and maintain a TB prevention and infection control program based on current guideline issued by the CDC. The policy indicated the licensee would screen staff for TB and provide training to educate staff regarding signs and symptoms of TB. The policy also indicated the licensee would maintain all reports of TB screening in the personnel files of employees. 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 (5) have a written policy and procedure regarding	0 680		

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0 680	Continued From page 9 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 observation, interview and record review, the licensee failed to post an emergency plan prominently and develop an emergency preparedness plan with all required content. This had the potential to affect all 27 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The finding include: During a facility tour with the regional vice president of operations (RVPO)-G on December 15, 2021, at approximately 11:30 a.m., the surveyors observed the facility had two floors of resident living units, including a secured memory care unit located on the first floor. The surveyors observed no signage posted regarding the licensees' emergency plan or emergency exit	0 680		

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0 680	Continued From page 10 diagrams. RVPO-G showed surveyors where the emergency exit diagrams were posted on each floor. The emergency exit diagrams were displayed in the stairwell on each floor but not easily accessible since the door to enter the stairwells had to be opened in order for the emergency exit diagram to be visible for residents and staff. RVPO-G stated there should be an emergency exit diagram posted on the door inside of every resident room. RVPO-G showed surveyors two resident rooms, and there was not an emergency exit diagram displayed in either room. On December 17, 2021, at 3:25 p.m., the RVPO-G confirmed licensee had not yet completed an emergency preparedness plan. The licensee's plan lacked evidence of the following requirements: -current, all-hazards approach facility assessment -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations. -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents' -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program;	0 680		

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0 680	Continued From page 11 -EP training program for staff (including documentation of training provided); -annual EP testing requirements The licensee's MN Disaster Planning and Emergency Preparedness policy, dated July 1, 2021, indicated the licensee would have a written emergency preparedness plan that is in alignment with facility's requirement to comply with Appendix Z as listed above. The policy indicated the licensee would have a written emergency disaster plan that contained a plan for evacuation, address elements of sheltering in place, identify temporary relocation sites, and detailed staff assignments in the event of a disaster or emergency. The policy also indicated the licensee would post emergency exit diagrams on each floor, and provide building emergency exit diagrams to all residents. No further information was provided. On December 16, 2021, at approximately 12:40 p.m., survey staff received the requested documentation for inspection, maintenance, and load test records of the emergency power generator as part of the facility's shelter-in-place emergency disaster and preparedness plan for review. On December 16, 2021, at approximately 1:30 p.m, the licensee failed to provide the minimum frequency of inspection, maintenance, and load test requirements for the emergency power generator as outlined under NFPA 110, (as referenced under the Code of Federal Regulations, title 42, section 483.73) to ensure proper performance of the generator as follows:	0 680		

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THE ENCORE AT MAPLEWOOD	2300 HAZELWOOD STREET MAPLEWOOD, MN 55109

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0 680	Continued From page 12 -Weekly inspections of the generator systems. Documentation review revealed the forms used for inspections, "perform scheduled maintenance on generator set in accordance with manufacturer's or NFPA 110", were not filled out to show the required inspection weekly checks were performed by the licensee. -Monthly generator load tests. Documentation review revealed the last monthly generator load tests on record were 4/12/2019 at 11:00 a.m., 3/8/2019 at 4:00 p.m., and 2/4/2019 at 1:42 p.m. and incomplete required monthly tests. -Monthly transfer switch operation tests. Based on the monthly generator load tests records provided, the last monthly transfer switch operation tests were concluded at the same time as monthly generator load tests. No other records were provided to support additional or more recent monthly transfer switch operation tests. On December 16, 2021, at approximately 2:30 p.m., the licensed assisted living director (LALD)-C acknowledged the findings. No other information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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0 780	Continued From page 13 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the smoke alarm in resident bedroom #120 as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect all 27 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 16, 2021, while on tour with the	0 780		

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0 780	Continued From page 14 director of maintenance (DM)-I at approximately 11:00 a.m., survey staff observed that the smoke alarm was missing from the bracket housing of resident bedroom #120. This finding was verified by the DM-I. On December 16, 2021, at approximately 2:30 p.m., survey staff discussed the missing smoke alarm in bedroom #120 with the licensed assisted living director (LALD)-C. Staff explained that although the room was currently not occupied by a resident, the missing smoke alarm may prevent the early notification of a fire which can delay the response time of the evacuation of all residents, employees, and visitors in the entire facility. The LALD-C acknowledged the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment including the floors of resident rooms #231 and #240, and the grounds of the facility in a	0 800		

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0 800	Continued From page 15 continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all 27 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 16, 2021, between 10:30 a.m. and 12:30 p.m., survey staff toured the facility with the director of maintenance (DM)-I. The DM-I explained that he was the backup for another employee that was on leave, and this was not his assigned facility. On December 16, 2021, while on tour at approximately 10:55 a.m., survey staff observed the fire door between the dining room and the kitchen on the dementia care floor (first) was partially in an opened position, and not able to self-close. The failure of the door to self close may comprise the fire separation during a fire, and also could be potentially harm to dementia residents entering the kitchen. The DM-I verified the finding as he stated that it was probably from wear and tear, and stated it was good to know. On December 16, 2021, at approximately 11:10 a.m., survey staff observed the return grille in the ceiling was heavily layered with dust. The DM-I concurred with the finding.	0 800		

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0 800	Continued From page 16 On December 16, 2021, at approximately 12:10 p.m., survey staff observed the carpet flooring in resident room #231 was heavily soiled and stained. This finding was verified by the DM-I as survey staff asked about the schedule of cleaning and vacuuming of the resident rooms. The DM-I stated that he did not know as this was not his facility to maintain. On December 16, 2021, at approximately 12:15 p.m., survey staff observed part of the carpet in the resident room #240 was stained and dirty with crumbs spread out on the floor. The DM-I verified the finding. On December 16, 2021, at approximately 12:20 p.m., survey staff observed the exhaust fan in the second-floor laundry room was heavily layered with dust. The DM-I verified the finding. On December 16, 2021, at approximately 2:30 p.m., the licensed assisted living director (LALD)-C also confirmed the findings during the interview. No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 17 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the required documentation on fire safety and evacuation plans and evacuation drills. In addition, the licensee failed to provide documentation on the required frequency of employee and resident training on evacuations. This has the potential to directly affect the safety of all 27 residents receiving assisted living care, staff, and visitors.	0 810		

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0 810	Continued From page 18 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). On December 16, 2021, between 10:30 a.m. and 12:30 p.m., survey staff toured the facility with the director of maintenance (DM)-I. The facility consisted of two floors of assisted living resident units, including a secured memory care unit located on the first floor. On December 16, 2021, at approximately 12:40 p.m., survey staff received the requested documentation on fire safety and evacuation plan, drills, and training from the licensed assisted living director (LALD)-C for review. The findings include: 1. Evacuation and fire safety plan and documentation were missing contents and not readily available within the facility. 2. The fire safety and evacuation plan documentation lacked the specific procedures for employee actions to be taken in the event of a fire and fire protection procedures necessary for addressing all residents including any unique resident-specific situations during an evacuation such as residents who were wheelchair-bound, on walkers, bedridden, and needing assistance during an evacuation. Fire safety and evacuation plan must specifically address procedures for assisted living residents with dementia care during an evacuation.	0 810		

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0 810	Continued From page 19 3. The fire protection procedures for residents. 4. The building layout with location and number of resident sleeping rooms in the fire safety and evacuation plan documentation. 5. An insufficient number of employee evacuation drills performed as required by statute at the minimum number of six drills annually. The un-dated facility fire drill policy stated drills were to be performed monthly covering all shifts, however, document review showed the last drill log was dated February 27, 2020, at 6:15 p.m. 6. The incorrect frequency of employee training on fire safety and evacuation documented in the facility policy to meet the minimum required training upon hire and twice a year. The undated facility policy (5.47) stated training was only required of new employee orientation. 7. No policy documented or records provided to show training of residents that can self assist in their evacuation during on the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. The policy must address residents on the second floor receiving care as well as any applicable residents on the first floor with dementia care determined to be capable of self-assist. On December 16, 2021, at approximately 10:50 a.m., during the facility tour of the first floor with DM-I, survey staff observed the facility lacked the building layout with location and numbers of resident sleeping rooms available. The DM-I explained none were posted. On December 16, 2021, at approximately 2:50 p.m. during the interview with LALD-C about the required building layout as part of the fire safety and evacuation plan, she explained there was a layout plan posted near the second-floor elevator, but no explanation for the first floor.	0 810		

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0 810	Continued From page 20 On December 16, 2021, at approximately 2:55 p.m., LALD-C acknowledged the findings during the documentation review discussion and interview. LALD-C also added that the licensee will conduct a fire drill next Monday and every month thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required	01380		

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01380	Continued From page 21 training content, including for medication and treatments, for two of two employees (unlicensed personnel (ULP)-A, ULP-B) 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) 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). Findings include: ULP-A and ULP-B were hired to provide direct care to the licensee's residents on April 16, 2021, and on August 24, 2021, respectively. On December 15, 2021, at 1:45 p.m., ULP-A was observed administering medications to the licensee's resident. ULP-A and ULP-B's employee records had documentation ULP-A and ULP-B completed training, but lacked any documentation of demonstrated competency for the following areas: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation;	01380		

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01380	Continued From page 22 -range of motioning and positioning; and -administering medications or treatments as required. On December 17, 2021 at approximately 1:30 p.m., regional vice president of operations (RVPO)-G verified ULP-A's and ULP-B's employee records lacked evidence of training and competency evaluations for ULP providing assisted living services. The licensee's Medication and Treatment-Administration and Delegation policy dated July 1, 2021, indicated the ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a registered nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	01440		

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01440	Continued From page 23 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-A, ULP-B) with employee 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 situation has occurred only occasionally). The findings include: ULP-A was hired by the licensee on April 16, 2021, to provide direct care to the licensee's residents. On December 15, 2021, at 1:45 p.m., ULP-A was observed administering medications to a resident.	01440		

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01440	Continued From page 24 ULP-A's employee records lacked evidence an RN conducted direct supervision of staff performing delegated tasks within 30 days of providing services. ULP-B was hired by the licensee on August 24, 2021, to provide direct care to the licensee's residents. ULP-B's employee records lacked evidence that a RN conducted direct supervision of staff performing delegated tasks within 30 days of providing services. On December 17, 2021 at approximately 1:30 p.m., regional vice president of operations (RVPO)-G verified ULP-A and ULP-B's employee records lacked evidence they were supervised by a RN within 30 days of performing delegated tasks. The licensee's Organization of Personnel Records policy dated July 1, 2021, indicated employee records were required to include delegated task documentation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated	01460		

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01460	Continued From page 25 into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for one of two employees (unlicensed personnel (ULP)-B) with employee 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 situation has occurred only occasionally). The findings include: ULP-B was hired by the licensee on August 24, 2021, to provide direct care to the licensee's residents. ULP-B's employee records lacked evidence the employee received orientation to include the following topics: - an overview of Assisted Living Laws 144G. - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30614	A. BUILDING: _____ B. WING _____	12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT MAPLEWOOD	2300 HAZELWOOD STREET MAPLEWOOD, MN 55109

(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
01460	Continued From page 26 -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services - a review of the types of assisted living services the employee would be providing and the facility's category of licensure On December 17, 2021, at approximately 11:30 a.m., licensed assisted living director (LALD)-C verified ULP-B's employee record lacked documentation of the above noted required training.. The licensee's Orientation of Staff and Supervisors policy dated July 1, 2021, indicated the orientation must include the above noted required training. The policy also indicated all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents.	01460		

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01460	Continued From page 27 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure unlicensed personnel (ULP) were specifically oriented to residents for two of two employees (ULP-A, ULP-B) with employee 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 situation has occurred only occasionally). Findings include: ULP-A and ULP-B were hired to provide direct care to the licensee's residents on April 16, 2021, and August 24, 2021, respectively. ULP-A and ULP-B's employee records lacked	01480		

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	30614	A. BUILDING: _____ B. WING _____	12/17/2021

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01480	Continued From page 28 documentation of orientation to individual residents and services. On December 17, 2021, at approximately 3:00 p.m., registered nurse (RN)-E reported she was not able to locate documentation ULP-A and ULP-B received orientation to each individual resident. The licensee's Orientation of Staff and Supervisors Policy dated July 1, 2021, indicated staff providing assisted living services must be oriented specifically to each individual resident and the services provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01480		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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	01540		

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01540	Continued From page 29 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required eight hours of dementia care training was completed within 80 hours of the employment start date for one of two employees (unlicensed personnel (ULP)-B) with employee 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 situation has occurred only occasionally). The findings include: ULP-B was hired by licensee on August 24, 2021, to provide assisted living services to the licensee's residents. ULP-B's employee record and training transcripts lacked evidence ULP-B completed the required dementia-care related training. On December 17, 2021, at approximately 3:00 p.m., regional vice president of operations (RVPO)-G provided documentation ULP-B had six hours of dementia training on August 26, 2021, from 9:00 a.m. to 3:00 p.m. and confirmed ULP-B's employee record lacked evidence of eight hours of the required dementia care training.	01540		

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	30614	A. BUILDING: _____ B. WING _____	12/17/2021

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01540	Continued From page 30 The licensee's Dementia Training policy dated July 1, 2021, indicated direct care employees would complete eight (8) hours of initial training within 80 hours of employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		
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	01790		

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	30614	A. BUILDING: _____ B. WING _____	12/17/2021

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01790	Continued From page 31 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 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	01790		

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01790	Continued From page 32 away from home when the licensed nurse was not available for two of two unlicensed personnel ((ULP)-A, ULP-B) 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 only occasionally). The findings included: ULP-A and ULP-B were hired to provide direct care to the licensee's residents on April 16, 2021, and August 24, 2021, respectively. ULP-A and ULP-B's employee records lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On December 17, 2021, at approximately 4:00 p.m., licensed assisted living director (LALD)-C verified no competencies were documented in the records of ULP-A and ULP-B regarding unplanned times away from home training for medications. The licensee's Medication Management - Planned and Unplanned Time Away policy dated July 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN may delegate this task to ULPs, if the RN had trained the ULP and determined the employee was competent to follow the procedures for giving medications to	01790		

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01790	Continued From page 33 residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		
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 a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazards and mitigations on and around the property. The hazards indicated on the HVA plan must be assessed and mitigated to protect the residents from harm. This has the potential to directly affect all 27 residents receiving assisted living services, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02040		

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02040	Continued From page 34 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 16, 2021, at approximately 10:25 a.m. and again at 12:30 p.m., survey staff requested complete documentation, including the HVA plan for review. At 1:30 p.m., no evidence of the HVA plan documentation was found to identify potential hazards and to address mitigations on and around the property to protect dementia residents from harm. On December 16, 2021, at approximately 2:30 p.m. during an interview with the licensed assisted living director (LALD)-C, survey staff explained that observations were made during the tour that the windows in resident rooms 109, 111, and 115 were compromised and may be opened by residents, allowing elopement. In addition, all other potential hazards on and around the property must also be assessed and mitigated in the plan to protect dementia residents from harm. The LALD-C confirmed that the facility had not yet developed the required HVA plan, and explained that she has been in this position for six weeks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *12/15/21*
Time: 08:54:05
Report: 7963211166

Food and Beverage Establishment Inspection Report

Location:
The Encore At Maplewood
2300 Hazelwood Street
Maplewood, MN55109
Ramsey County, 62

Establishment Info:
ID #: 0037801
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517773316
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD MANAGER. DEENA BELL HAS TAKEN AN APPROVED FOOD SAFETY CLASS AND HAS APPLIED FOR CFM CERTIFICATE.

Comply By: 12/16/21

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

SECOND FLOOR REFRIGERATOR DOES NOT HAVE A THERMOMETER. CORRECTED ON SITE.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

ICE MAKER BIN HAS AN ACCUMULATION OF MOLD ON DRIP LINE. CLEAN AND SANITIZE.

Type: Full
Date: *12/15/21*
Time: 08:54:05
Report: 7963211166
The Encore At Maplewood

Food and Beverage Establishment Inspection Report

Comply By: 12/16/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SANI DISPENSER
Violation Issued: No

Hot Water: = at 169 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: PASTA CASSEROLE
Temperature: 35 Degrees Fahrenheit - Location: WALKIN
Violation Issued: No

Process/Item: MILK
Temperature: 35 Degrees Fahrenheit - Location: WALKIN
Violation Issued: No

Process/Item: COLESLAW
Temperature: 35 Degrees Fahrenheit - Location: WALKIN
Violation Issued: No

Process/Item: MILK
Temperature: 37 Degrees Fahrenheit - Location: 2ND FLOOR REFRIGERATOR
Violation Issued: No

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

THIS INSPECTION IS PART OF AN HRD SURVEY OF AN ASSISTED LIVING FACILITY. MET WITH LEAD SURVEYOR ROBYN WOOLLEY (WITH HRD) AND
FOODSERVICE PERSON IN CHARGE- DEENA BELL.
THIS ESTABLISHMENT HAS A SINGLE KITCHEN FOR FOOD PREPARATION. RESIDENTS RECEIVE PLATED MEALS FROM THE MAIN
KITCHEN WHICH ARE THEN HANDED OUT DIRECTLY TO RESIDENTS.
AN ACTIVITY KITCHEN IS LOCATED ON THE SECOND FLOOR. THE REFRIGERATOR IS USED TO STORE MILK AND SNACKS FOR IN BETWEEN MEALS.

THE ESTABLISHMENT IS CURRENTLY USING AN UNFINISHED SPACE (MECHANICAL ROOM) TO STORE DRY GOODS AND PAPER PRODUCTS. RELOCATE THESE ITEMS TO AN APPROVED AREA.

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 7963211166 of 12/15/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____

Denna Bell
PIC

Signed:_____

Peggy Spadafore
Sanitatian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us