DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 10, 2022

Administrator
Park Gardens of Fergus Falls
215 East Skogmo Boulevard
Fergus Falls, MN 56537

RE: Project Number SL30541015

Dear Administrator:

On August 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 11, 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,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 218-332-5175| Fax: 218-332-5196

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Electronically Delivered
June 1, 2022

Administrator
Park Gardens Of Fergus Falls
215 East Skogmo Boulevard
Fergus Falls, MN 56537

RE: Project Number SL30541015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 11, 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 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $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,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 218-332-5175| Fax: 218-332-5196

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30541	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK GARDENS OF FERGUS FALLS	215 EAST SKOGMO BOULEVARD FERGUS FALLS, MN 56537

(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#30541015 On May 9, 2022, through May 11, 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 60 residents, all of whom recieved services under the provider's Assisted Living with Dementia Care license. An immediate correction order was identified on May 9, 2022, issued for SL30541015, tag identification 2310. On May 12, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at an isolated scope and level of three (G).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 had the potential to affect all of the licensee's current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 document titled, Food and Beverage Establishment Inspection Report dated	0 480		

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0 480	Continued From page 2 May 9, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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 facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly 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) 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 residents). The findings include: On May 11, 2022, from approximately 10:25 a.m. to 3:30 p.m., survey staff toured the facility with	0 800		

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0 800	Continued From page 3 licensed assisted living director (LALD)-C and director of maintenance (DM)-N. During the facility tour, survey staff observed and verified the following: -The gate for the memory courtyard had a padlock installed and was locked from the outside of the fenced-in courtyard limiting a means of egress during a fire or similar emergency from inside the courtyard. This was evident as the memory care unit had two identified exit doors inside the building and the facility's evacuation plan both directed to exit into the locked courtyard. -The fire rated door for the mechanical room on the main floor was propped open with a door wedge during and after the survey of the mechanical room. The LALD-C verified the finding as he stated that the door was kepted open for survey. Survey staff explained that all fire rated doors serving hazardous rooms such as the mechanical room must be closed at all times or be installed with a magnetic holder to protect the rated corridors for safe path of egress during a fire. -The fire rated door on the second floor laundry room failed to shut tight to latch. -The fire rated door on the first floor laundry room failed to shut tight to latch. -The water line serving the chemical soap dispenser from the mop sink faucet was not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the potable water supply. On May 11, 2022, at approximately 3:45 p.m., LALD-C and DM-N verbally confirmed survey staff observations during the facility tour. Survey staff explained that an option to have a secured courtyard for the memory care residents was to	0 800		

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0 800	Continued From page 4 add a magnetic lock to the courtyard gate that releases when the building fire alarm system is activated. Staff emphasized to the LALD-C that they should review the locked courtyard and exit signs with the local fire official if any of the means of egress or exit signs for any alterations for compliance with the fire code. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=E	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

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0 810	Continued From page 5 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 the interview and record review, the licensee failed to provide the required employee evacuation drills. This has the potential to directly affect all 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 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: On May 11, 2022, at approximately 2:35 p.m., survey staff reviewed the facility fire safety and evacuation plan and related documentation. On May 11, 2022, at approximately 3:30 p.m., document review showed the minimum number of evacuation drills performed by employees failed to meet the minimum frequency as required. Record review indicated evacuation drills performed were quarterly with dates of November 30, 2021, and February 28, 2022. The maintenance director (DM)-N verified the finding	0 810		

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0 810	Continued From page 6 as he explained that he had started employment with the facility at the end of January. On May 11, 2022, at approximately 3:45 p.m., the DM-N and the assisted living director-C acknowledged the finding during the exit interview. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;	0 940		

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0 940	Continued From page 7 (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for four of four residents (R1, R2, R3, R5) with records reviewed. This had the potential to affect all 60 residents of the facility. 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: R1's Resident Agreement for Assisted Living was signed by the resident on October 4, 2021. R2's Resident Agreement for Assisted Living was signed by the resident and the responsible person on July 26, 2021. R3's Resident Agreement for Assisted Living was	0 940		

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0 940	Continued From page 8 signed dated September 13, 2021. R5's Resident Agreement for Assisted Living was signed dated September 20, 2021. R1, R2, R3, and R5's Resident Agreements for Assisted Living contract lacked a description of the facility's policies related to medical assistance waivers and the housing support programs to include: -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. On May 10, 2022, at approximately 1:56 p.m., licensed assisted living director (LALD)-C stated their facility accepted residents who are on waivers or public support and also said "we have no requirement" that a resident has to pay privately for a time to live here. However, LALD-C acknowledged this information (described above) was missing on their contract. LALD-C said all residents would have the same contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action.	0 980		

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0 980	Continued From page 9 (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident agreement arbitration requirement did not include a choice of venue provision. This practice resulted in a level one violation, 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: The licensee's contract used for all residents included an Arbitration Agreement section. The section included a paragraph titled Location of Arbitration and indicated "the Arbitration will be conducted at a site selected by Park Gardens of Fergus Falls which shall be either at Park Gardens of Fergus Falls or somewhere within a reasonable distance of Park Gardens of Fergus Falls." On May 10, 2022, at approximately 11:30 a.m., licensed assisted living director (LALD)-C confirmed all resident agreements included an arbitration agreement that incorporated a choice of law and choice of venue provision. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 980		

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0 980	Continued From page 10 (21) days	0 980		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the facility for one of one unlicensed personnel (ULP-F) 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 situation has occurred only occasionally). The findings include: During the entrance conference on May 9, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-C confirmed the licensee was utilizing two contracted ULP to maintain staffing for the facility. ULP-F was contracted on February 7, 2022, to provide direct care services to the licensee's residents. ULP-F's employee file lacked evidence	01350		

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PARK GARDENS OF FERGUS FALLS	215 EAST SKOGMO BOULEVARD FERGUS FALLS, MN 56537

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01350	Continued From page 11 of competency training for administering medications. ULP-F's employee file lacked evidence ULP-F was supervised within 30 days of performing delegated tasks, as required. On May 10, 2022, at approximately 8:10 a.m., registered nurse (RN)-A confirmed medication training was completed with ULP-F and the training was the same as what a ULP employed by the licensee would get. RN-A confirmed documentation of the medication competency training was not in the employee file for ULP-F. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 12	01620		

calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the Uniform Assessment Tool for four of four residents (R1, R2, R3, R5) as required 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 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:

R1
R1's diagnoses included dementia, memory loss, and type two diabetes.

R1's service plan, dated January 12, 2022, indicated the resident received the following services: medication set up, medication administration, safety checks, meal reminders and escorts, and housekeeping and laundry.

R1's most recent 90 day reassessment, dated

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01620	Continued From page 13 April 9, 2022, did not include all the required content for the Uniform Assessment Tool. R2 R2's diagnoses included type two diabetes, hypertension, and schizoaffective disorder. R2's service plan, dated March 2, 2022, indicated the resident received the following services: medication administration, insulin injections, blood glucose monitoring, and housekeeping and laundry. R2's most recent 90 day reassessment, dated February 13, 2022, did not include all the required content for the Uniform Assessment Tool. R3 R3's diagnoses included disorder of adult personality and behavior, hypertension, osteoporosis, hypothyroidism, anxiety and depression. R3's service plan, dated March 30, 2022, indicated the resident received the following services: assistance with activities of daily living and transfers; medication management; escort assistance; and housekeeping and laundry. R3's most recent 90-day assessment, dated May 4, 2022, did not include all required content for the Uniform Assessment Tool. R5 R5's diagnoses included Lewy Bodies dementia, disturbance of memory, ataxia, hyperlipidemia, anemia and osteoarthritis. R5's service plan, dated January 12, 2022, indicated the resident received the following	01620		

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01620	Continued From page 14 services: medication set up, medication administration, safety checks, meal reminders and escorts, and housekeeping and laundry. R5's most recent 90 day reassessment, dated April 13, 2022, did not include all the required content for the Uniform Assessment Tool. The reassessments for R1, R2, R3, and R5 were missing the following required content: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order; B. activities of daily living, including: (1) toileting pattern, bowel, and bladder control; (2) dressing, grooming, bathing, and personal hygiene; (3) mobility, including ambulation, transfers, and assistive devices; and (4) eating, dental status, oral care, and assistive devices and dentures, if applicable; C. instrumental activities of daily living, including: (2) housework and laundry; and (3) transportation; D. physical health status, including: (1) a review of relevant health history and current health conditions, including medical and nursing diagnoses; (2) allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life	01620		

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01620	Continued From page 15 threatening; (3) infectious conditions; (4) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) the reason taken; (b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (c) the dosage; (d) the frequency of use; (e) the route administered or taken; (f) any difficulties the resident faces in taking the medication; (g) whether the resident self administers the medication; (h) the resident's preferences in how to take medication; (i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; (6) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months; (7) weight; and (8) initial vital signs if indicated by health conditions or medications; E. emotional and mental health conditions, including: (1) review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral	01620		

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01620	Continued From page 16 disorders; (2) current symptoms of mental health conditions and behavioral expressions of concerns; and (3) effective medication treatment and nonmedication interventions; F. cognition, including: (1) a review of any neurocognitive evaluations and diagnoses; and (2) current memory, orientation, confusion, and decision-making status and ability; G. communication and sensory capabilities, including: (1) hearing; (2) vision; (3) speech; (4) assistive communication and sensory devices including hearing aids; and (5) the ability to understand and be understood; H. pain, including: (1) location, frequency, intensity, and duration; and (2) effectiveness of medication and nonmedication alternatives; I. skin conditions; J. nutritional and hydration status and preferences; K. list of treatments, including type, frequency, and level of assistance needed; L. nursing needs, including potential to receive nursing-delegated services; M. risk indicators, including: (1) risk for falls including history of falls; (2) emergency evacuation ability; (3) complex medication regimen; (4) risk for dehydration, including history of urinary tract infections and current fluid intake pattern; (6) unsuccessful prior placements; (7) elopement risk including history or previous elopements;	01620		

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01620	Continued From page 17 (9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; N. who has decision-making authority for the resident, including: (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and (2) the scope of decision-making authority of a substitute decision maker under subitem (1); and the need for follow-up referrals for additional medical or cognitive care by health professionals. On May 10, 2022, at approximately 8:10 a.m., regional director (RD)-H confirmed the assessments used for all residents lacked some of the required content of the Uniform Assessment Tool. RD-H stated they were working on updating their assessments to ensure it [assessment] included all the required content but had not been able to implement the new assessment yet. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	01940		

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01940	Continued From page 18 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R5) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01940		

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01940	Continued From page 19 The findings include: R5's diagnoses included Lewy Bodies dementia, disturbance of memory, ataxia, hyperlipidemia, anemia and osteoarthritis. R5's service plan, dated January 12, 2022, indicated the resident received the following services: medication set up, medication administration, safety checks, meal reminders and escorts, and housekeeping and laundry. On May 9, 2022, at approximately 11:09 a.m., R5 was seated in a recliner chair in the day room area. The surveyor observed R5 wearing some kind of compression device/stockings on both legs, which were covered by gripper socks. On May 9, 2022, at approximately 1:32 p.m., unlicensed personnel (ULP)-K verified R5 wore compression socks, stating she thought they were referred to as "tubigrips" (a tubular, elastic bandage fitted over a body limb to provide tissue support and compression used to treat soft tissue injuries and edema). ULP-K stated they were put on in the morning and helped keep R5's legs from swelling and also provide support following her fall. R5's Service Plan/Medication Treatment therapy Management Plan lacked the following content: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatment or therapy administration; -identification of the treatment or therapy that will be delegated to unlicensed personnel; -procedures for notifying a nurse or appropriate licensed health professional when a problem	01940		

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01940	Continued From page 20 arises with the treatments or therapy services; and -any resident-specific requirements relating to documenting of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 10, 2022, at approximately 9:55 a.m., licensed practical nurse (LPN)-M confirmed R5 wore a compression device and was certain there was an order for the "tubi grips" but was unable to locate it in the resident's record. LPN-M stated the directions for Tubigrips should be in R5's MAR (medication administration record). LPN-M also said there should be specific instructions for when to put on and take off, usually washing instructions and also to monitor for swelling. LPN-M was unable to find the details for the compression device in R5's chart and stated "it should be there." On May 10, 2022, at approximately 12:30 p.m. registered nurse (RN)-A verified that neither R5's service plan nor medication/treatment management plan included the treatment for R5's use of the Tubigrips compression device. RN-A stated the resident had began using them [Tubigrips] at some point following a fall. RN-A stated the information should be on R5's treatment plan with directions and there should be an order for them [Tubigrips] and also documentation of the service. RN-A verified they were not doing this for R5's treatment. The licensee's Medications & Treatment guideline document, reviewed August 2021, indicated as its purpose to ensure medications and treatments systems are in accordance to the comprehensive	01940		

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01940	Continued From page 21 Home Care regulations and in the scope of Assisted Living. The document indicated the Medication and Treatment Management Plan will be completed for all tenants receiving services prior to initiating services. The treatment management plan will: describe the treatment service provided; document specific instructions for treatments; identify treatments delegated to unlicensed personnel; and identify specific instructions for documenting treatment administration verification. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and	01950		

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01950	Continued From page 22 (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) specified, in writing, specific instructions for each resident with a treatment and documented those instructions in the resident's record for one of one resident who wore a compression device (R5) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients 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 Lewy Bodies dementia, disturbance of memory, ataxia, hyperlipidemia, anemia and osteoarthritis. R5's service plan, dated January 12, 2022, indicated the resident received the following services: medication set up, medication administration, safety checks, meal reminders and escorts, and housekeeping and laundry services. On May 9, 2022, at approximately 11:09 a.m., the surveyor observed R5 seated in a recliner chair in the day room area. R5 was observed wearing	01950		

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01950	Continued From page 23 some kind of compression device/stockings on both legs, which were covered by gripper socks. On May 9, 2022, at approximately 1:32 p.m., unlicensed personnel (ULP)-K verified R5 wore compression socks, stating she thought they were referred to as "tubi grips" (a tubular, elastic bandage fitted over a body limb to provide tissue support and compression used to treat soft tissue injuries and edema). ULP-K stated they were put on in the morning and helped keep R5's legs from swelling and also provide support following her fall. ULP-K also stated she had been trained on how to put compression socks on a resident. R5's record lacked specific instructions for use of the Tubigrip/compression device. On May 10, 2022, at approximately 9:55 a.m., licensed practical nurse (LPN)-M said there should be specific instructions for when to put on and take off, usually washing instructions and also to monitor for swelling. LPN-M was unable to find the details for the compression device in R5's chart and stated "it should be there." On May 10, 2022, at approximately 12:30 p.m. registered nurse (RN)-A acknowledged RN-A R5 had began using Tubigrips at some point following a fall. RN-A stated this should be on R5's treatment plan with directions, and there should be an order for them and also documentation of the service. RN-A verified these things were not being done for R5's treatment. The licensee's Medications & Treatment guideline document, reviewed August 2021, indicated as its purpose to ensure medications and treatments systems are in accordance to the comprehensive Home Care regulations and in the scope of	01950		

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01950	Continued From page 24 Assisted Living. The document indicated all treatment/therapy to be administered as prescribed and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed, or to document the reason they were not provided for one of one resident (R5) who wore a compression device, with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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	01960		

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	30541	A. BUILDING: _____ B. WING _____	05/11/2022

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01960	Continued From page 25 limited number of clients 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 Lewy Bodies dementia, disturbance of memory, ataxia, hyperlipidemia, anemia and osteoarthritis. R5's service plan, dated January 12, 2022, indicated the resident received the following services: medication set up, medication administration, safety checks, meal reminders and escorts, and housekeeping and laundry. On May 9, 2022, at approximately 11:09 a.m., the surveyor observed R5 seated in a recliner chair in the day room area. R5 was observed wearing some kind of compression device/stockings on both legs, which were covered by gripper socks. On May 9, 2022, at approximately 1:32 p.m., unlicensed personnel (ULP)-K verified R5 wore compression socks, stating she thought they were referred to as "tubi grips" (a tubular, elastic bandage fitted over a body limb to provide tissue support and compression used to treat soft tissue injuries and edema). ULP-K stated they were put on in the morning and helped keep R5's legs from swelling and also provide support following her fall. On May 10, 2022, at approximately 9:55 a.m., licensed practical nurse (LPN)-M confirmed R5 wore a compression device and was certain there was an order for the "tubi grips" but was unable to locate it in the resident's record. LPN-M stated the directions for putting them should be in R5's MAR (medication administration record). LPN-M	01960		

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01960	Continued From page 26 said she thought documentation for the Tubigrips would be on their "Service Checkoff" and located in dressing/grooming section. LPN-M verified there was no mention of Tubigrips in the description of what the caregivers would document and looked like there was no documentation of this activity. On May 10, 2022, at approximately 12:30 p.m. registered nurse (RN)-A said they should be documenting the service. RN-A verified they were not documenting R5's treatment. The licensee's Medications & Treatment guideline document, reviewed August 2021, indicated as its purpose to ensure medications and treatments systems are in accordance to the comprehensive Home Care regulations and in the scope of Assisted Living. The document indicated all treatment/therapy to be administered as prescribed and documented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	01970		

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01970	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R5) who received a treatment. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients 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 Lewy Bodies dementia, disturbance of memory, ataxia, hyperlipidemia, anemia and osteoarthritis. R5's service plan, dated January 12, 2022, indicated the resident received the following services: medication set up, medication administration, safety checks, meal reminders and escorts, and housekeeping and laundry. On May 9, 2022, at approximately 11:09 a.m., the surveyor observed R5 seated in a recliner chair in the day room area. R5 was observed wearing some kind of compression device/stockings on both legs, which were covered by gripper socks. On May 9, 2022, at approximately 1:32 p.m., unlicensed personnel (ULP)-K verified R5 wore compression socks, stating she thought they were referred to as "tubi grips" (a tubular, elastic	01970		

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01970	Continued From page 28 bandage fitted over a body limb to provide tissue support and compression used to treat soft tissue injuries and edema). ULP-K stated they were put on in the morning and helped keep R5's legs from swelling and also provide support following her fall. R5's record lacked a current order for the application of Tubigrips/compression device. On May 10, 2022, at approximately 9:55 a.m., licensed practical nurse (LPN)-M confirmed R5 wore a compression device and was certain there was an order for the "tubi grips" but was unable to locate it in the resident's record. On May 10, 2022, at approximately 12:30 p.m., registered nurse (RN)-A R stated R5 had began using them [tubigrips] at some point following a fall. RN-A stated this should be on R5's treatment plan with directions and there should be an order for them and also documentation of the service. RN-A verified there were not doing this for R5's treatment. The licensee's Medications & Treatment guideline document, reviewed August 2021, indicated as its purpose to ensure medications and treatments systems are in accordance to the comprehensive Home Care regulations and in the scope of Assisted Living. The document indicated a written prescriber's order must be obtained for any treatment/medication provided to a tenant. Further, the order must be dated, contain the name of the medication/treatment, indicated, signed by the prescriber and must be current and consistent with the nursing assessment. No further information was provided.	01970		

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01970	Continued From page 29 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
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 observation, document review, and interview, the licensee failed to provide a complete hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect the residents from potential harm. This has the potential to directly affect all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents).	02040		

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02040	Continued From page 30 The findings include: On May 11, 2022, at approximately 3:30 p.m., survey staff conducted document review of the licensee's hazard vulnerability assessment plan, undated Kaiser Permanente Tool with the assisted living director (LALD)-C and director of maintenance (DM)-N. -The plan documentation lacked specific hazard content on the assessment on and around the property to protect the memory care residents from harm. Hazard assessments on the plan must also include specific safety risks or potential hazard vulnerabilities such as resident elopement as a potential risk from deactivation of power doors due to loss of power or fire alarm activation, the risk of the resident room windows being compromised, potential risks of resident handling or using a scissor without supervision for the resident in room #11 or residents having an appliance such as a coffee brewing machine in room #4, the risks of the misuse by accessing the portable fire extinguishers and/or architectural accessories, and potential risk around the property such as busy roads and nearyly ponds due to resident elopement. - The plan documentation lacked mitigation to each assessed risk to ensure effectively respond to all potential hazards that could directly affect all memory care residents. Specific prevention measures to mitigate risks from the identified potential hazard and vulnerability assessment must be developed and documented in the plan for all potential situations. On May 11, 2022, at approximately 3:45 p.m., survey staff discussed the findings and explained to the LALD-C and DM-N that all potential safety	02040		

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02040	Continued From page 31 risks or harm on and around the property must be identified, assessed, and mitigated and be documented in the licensee's plan. The LALD-C and DM-N acknowledged the findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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 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;	02110		

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02110	Continued From page 32 (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 develop and implement all required policies and procedures related to dementia care. 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: The licensee was licensed as an Assisted Living with Dementia Care facility on August 1, 2021. On May 9, 2022, at approximately 10:00 a.m., the licensee's assisted living with dementia care policies and procedures were requested from registered nurse (RN)-A and licensed assisted living director (LALD)-C. The policies and procedures provided did not include the following: -Evaluation of behavioral symptoms and design	02110		

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02110	Continued From page 33 of supports for intervention plans, including nonpharmacological practices that are 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; -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 May 9, 2022, at approximately 3:15 p.m., regional director (RD)-D confirmed the licensee had developed procedures but had not developed the above required policies and that residents were not signing off that they had received the required dementia care policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310		

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02310	Continued From page 34 Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R3, R4) who utilized bed rails with records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3's diagnoses included dementia, hypertension, anxiety and unspecified disorder of adult personally and behavior. On May 9, 2022, at approximately 1:17 p.m., the surveyor observed a metal assist rail on the exit side of R3's bed. The device was a tube shaped, that extended vertically upwards, and looked like a flattened circle. There was a gap between where the rail angled upwards and where the rail ended. The rail was fastened to a board about 18" x 24", and the board was positioned between the mattress and the box spring, which supported the rail device. R3's record lacked an assessment of the rail including documentation of the measurements oof the rail and assessments of the zones of entrapments.	02310		

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02310	Continued From page 35 On May 9, 2022, at approximately 4:15 p.m., registered nurse (RN)-A stated the licensee's assessments for bed rails do not contain measurements. RN-A stated R3 has been on therapy and therapy has assessed the necessity of the rail, but she did not know if they had assessed the safety of the rail. On May 9, 2022, at approximately 4:25 p.m., the surveyors and RN-A entered R3's room to measure R3's rail. The rail was 20 ½ inches high and 14 ½ inches wide. The opening of the rail measured 5 ½ inches tall and 12 inches wide. When the surveyor pulled on the device away from the bed, the mattress lifted and created a gap between the rail and mattress. The rail was fastened to the frame with a cloth strap which did not appear to keep the rail tight against the bed frame. RN-A verified this finding. R4 R4's diagnoses included vascular dementia. On May 9, 2022, at approximately 12:17 p.m. the surveyor observed a metal assist rail on the exit side of R4's bed. The device was a tube shaped, that extended vertically upwards and looked like a flattened circle. There was space between where the rail angled upwards and where the rail ended. The rail was fastened to a wooden board about 18" x 24", and the board was positioned between the mattress and the box spring, which supported the rail device. On May 9, 2022, at approximately 2:07 p.m., unlicensed personnel (ULP)-E stated R4 used the rail "all the time" saying R4 used it to get himself up from a lying position in bed, to sit up before getting meds or when R4 had to sit up in bed before going to the bathroom.	02310		

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02310	Continued From page 36 R4's record lacked an assessment of the rail including documentation of the measurements of the rail and the zones of entrapments. On May 9, 2022, at approximately 4:20 p.m., the surveyors and RN-A entered R4's room to observe the rail in the R4's room. RN-A stated she really did not know exactly how to measure the rail, had never done it before and acknowledged she did not know the zones of entrapment. RN-A measured R4's rail and it was 20 ½ inches tall and 14 ½ inches wide, and the opening (inner measurements) were 5 ½ inches tall and 12 inches wide. The space or gap between where the rail ended, and the circular part of the rail was 4 inches. There was no gap noted between the rail and mattress. RN-A stated she did not know if the board, on which the rail was fastened, was secured to the bed frame. The licensee's Assistive Device Assessment policy, revised February 2019, indicated as its purpose to assist in making appropriate decision in the care of a resident/tenant/client with the goal of a safe and comfortable bed and sleep environment. The policy indicated the Assistive Device Assessment will be completed for all residents who utilize a side rail, grab bar, alarm or other physical device. Under the safety guidelines section, the policy indicated the bars within the safety bar/rail are closely spaced to prevent a resident/tenants/clients head from passing through the openings. The policy indicated the rail should be securely fastened to the bed frame. The policy did not address zones of entrapment or what the assessment should contain. No further information was provided.	02310		

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02310	Continued From page 37 TIME PERIOD FOR CORRECTION: Seven (7) days On May 12, 2022, the immediacy of correction order 2310 was removed, however, non-compliance remained at an isolated scope and level of three (G).	02310		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *05/09/22*
Time: 11:00:00
Report: 7935221116

Food and Beverage Establishment Inspection Report

Location:
Park Gardens Of Fergus Falls
215 East Skogmo Boulevard
Fergus Falls, MN56537
Otter Tail County, 56

Establishment Info:
ID #: 0037589
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189984444
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17A ** Priority 2 **

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

DICED HAM DIDN'T HAVE A DATE MARK IN WALK IN COOLER. KITCHEN MANAGER DATE MARKED IT DURING INSPECTION.

Corrected on Site

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

REMOVE JESSICA'S CERTIFICATE. SHE NO LONGER WORKS AT ESTABLISHMENT. ALICIA'S SERVSAFE CERTIFICATE IS POSTED. POST STATE CERTIFICATE ONCE IT IS RECEIVED.

Comply By: 05/31/22

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

DICED HAM IN WALK IN COOLER. KITCHEN MANAGER PUT A LABEL ON DURING INSPECTION.

Corrected on Site

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

BAGS OF CEREAL ON FLOOR UNDER SHELVING IN DRY STORAGE ROOM. KITCHEN MANAGER MOVED THEM TO A DIFFERENT LOCATION DURING INSPECTION.

Corrected on Site

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

UTENSILS HANGING NEXT TO FRONT HAND WASHING SINK. MOVE UP HIGHER, SO THAT THEY DON'T GET SPLASHED ON WHILE WASHING HANDS.

Comply By: 05/09/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

FLOOR WERE STICKY, FOOD DEBRIS/TRASH OBSERVED UNDER EQUIPMENT IN KITCHEN AND SHELVING IN DRY STORAGE ROOM. KITCHEN MANAGER SAID THAT THEY ARE SCHEDULED TO HAVE FLOORS AND WALLS STEAM CLEANED.

Comply By: 05/16/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Three Comp Sink
Violation Issued: No

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 164 Degrees Fahrenheit - Location: Chicken
Violation Issued: No

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

Type: Full
Date: *05/09/22*
Time: 11:00:00
Report: 7935221116
Park Gardens Of Fergus Falls

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Walk In
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	5

There was a box of unpasteurized eggs in walk in cooler. These were delivered from food service provider in error and kitchen manager is waiting for truck to return product.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

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

I acknowledge receipt of the MN Department of Health inspection report number 7935221116 of 05/09/22.

Certified Food Protection Manager: Alicia Triemert

Certification Number: 100939 Expires: 10/07/22

Signed:_____ Signed: 7935

Establishment Representative

651-201-4500
health.foodlodging@state.mn.us