DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 24, 2022

Administrator
Ecumen Seasons At Maplewood
1670 Legacy Parkway East
Maplewood, MN 55109

RE: Project Number(s) SL27398015

Dear Administrator:

On May 23, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the March 9, 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,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

Electronically Delivered

April 20, 2022

Administrator
Ecumen Seasons At Maplewood
1670 Legacy Parkway East
Maplewood, MN 55109

RE: Project Number(s) SL27398015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 9, 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

The total amount you are assessed is $3,000. 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:	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

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,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27398	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST 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 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#27398015 On March 7, 2022, through March 9, 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 112 residents; 67 receiving services under the provider's Assisted Living with Dementia Care license. On March 9, 2022, the immediacy of correction order 2310 has been removed, however non-compliance remains at a scope of widespread and level 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 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 and Beverage Establishment Inspection Report dated March 8, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for six of six residents (R1, R2, R3, R4, R5, R6) 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	0 630		

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0 630	Continued From page 3 or has the potential to affect a large portion or all of the residents). The finding include: On March 8, 2022, at approximately 11:00 a.m., director of nursing (DON)-E, indicated all resident's individualized abuse prevention plans (IAPP) would be included in the resident's Resident Contract document. R1's Resident Contract dated August 1, 2021, lacked assessment of the resident's susceptibility to abuse by another individual; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse. R2's Resident Contract dated February 27, 2022, lacked assessment of the resident's susceptibility to abuse by another individual; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse. R3's Resident Contract dated February 15, 2022, lacked assessment of the resident's susceptibility to abuse by another individual; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse. R4's Resident Contract dated December 4, 2021, lacked assessment of the resident's susceptibility to abuse by another individual; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse. R5's Resident Contract dated November 30,	0 630		

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0 630	Continued From page 4 2021, lacked assessment of the resident's susceptibility to abuse by another individual; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse. R6's Resident Contract dated February 22, 2022, lacked assessment of the resident's susceptibility to abuse by another individual; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse. On March 9, 2022, at approximately 1:30 p.m., DON-E acknowledged that while the IAPPs developed for each resident did address some areas of vulnerability, they failed to address each resident's susceptibility to abuse by another individual; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse. The licensee's Individual Abuse Prevention Plans policy dated July 17, 2021, indicated all required content for the IAPP for each resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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:	0 650		

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0 650	Continued From page 5 (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 observation, interview, and record review, the licensee failed to ensure a background study was completed and documented for one of one licensed practical nurse (LPN)-A with record 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	0 650		

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0 650	Continued From page 6 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: LPN-A was hired April 23, 2021. On March 8, 2022, at approximately 8:30 a.m., LPN-A was observed to give unlicensed personnel (ULP)-B instructions for a dropped medication for R6. LPN-A took dropped medication from ULP-B for destruction and documentation of destruction. LPN-A's record lacked documentation of a completed and cleared background study. On March 7, 2022, at approximately 1:30 p.m., executive director (ED)-C acknowledged documentation of LPN-A's background study was not included in their employee record. ED-C stated one was completed through NetStudy 2.0 (website for background studies), but with the transition to the assisted living with dementia care licensure, the licensee failed to obtain a printed copy for LPN-A's record. ED-C stated a new one would be initiated immediately as licensee was no longer able to access the background studies completed under the previous license. The licensee's Background Checks policy dated July 27, 2021, indicated all employees would pass and have a completed background study. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 650		

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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; (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 required	0 810		

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0 810	Continued From page 8 content on the fire procedure for residents in the fire safety and evacuation plan, minimum number of required employee evacuation drills, and required documentation on training of residents on fire safety and evacuation. This has the potential to directly affect the safety of staff and all residents receiving care. 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 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 clients). The findings include: On March 9, 2022, between the hours of 9:35 a.m. and 12:05 p.m., survey staff toured the facility with the executive director (ED)-C and the environmental director(D)-G. On March 9, 2022, at approximately 12:15 pm, survey staff received the facility fire safety and evacuation plan, training, drills, and related documentation for review: FIRE SAFETY AND EVACUATION PLAN -The building layout plan lacked the identification of locations and the number of sleeping rooms. -The documentation lacked fire protection procedures for the residents. TRAINING The policy documentation lacked the content of training for residents who are capable of assisting in their own evacuation on proper actions to take during a fire event to include movement,	0 810		

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0 810	Continued From page 9 evacuation, or relocation. The training must be available to residents at least once a year. FIRE AND EVACUATION DRILLS The policy documentation specified the correct minimum number of employee evacuation drills to be performed for each of the shifts, but further record review showed an insufficient number of evacuation drills performed to date by employees and did not cover all three shifts. Documented records of evacuation drills were on 2/28/2022, at 7:00 a.m., 11/30/2021, at 3:00 p.m., 9/28/2021, at 9:30 a.m. 6/30/2021, at 9:30 a.m. On March 9, 2022, at approximately 2:30 p.m., the ED-C and the D-G acknowledged the findings as they stated that they planned to perform an evacuation drill for third shift soon. Survey staff explained that the drill frequency must also be performed to meet the requirement of at least one every other month for a total of at least six drills annually. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950		

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0 950	Continued From page 10 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative's statutory language for five of six residents (R1, R2, R4, R5, R6) 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 the residents).	0 950		

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ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST MAPLEWOOD, MN 55109

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0 950	Continued From page 11 The findings include: On March 07, 2022, at approximately 10:30 a.m., director of nursing (DON)-E provided a blank Assisted Living Contract and indicated the contract is used by licensee for all residents who received services by licensee. R1's record included a copy of the Assisted Living Contract dated August 1, 2021. R1's Assisted Living Contract lacked the verbatim "right to designate a representative for certain purposes" notice required at the time of execution of the contract. R2's record included a copy of the Assisted Living Contract dated February 27, 2022. R2's Assisted Living Contract lacked the verbatim "right to designate a representative for certain purposes" notice required at the time of execution of the contract. R4's record included a copy of the Assisted Living Contract dated December 4, 2021. R4's Assisted Living Contract lacked the verbatim "right to designate a representative for certain purposes" notice required at the time of execution of the contract. R5's record included a copy of the Assisted Living Contract dated November 30, 2021. R5's Assisted Living Contract lacked the verbatim "right to designate a representative for certain purposes" notice required at the time of execution of the contract. R6's record included a copy of the Assisted Living Contract dated February 22, 2022. R6's Assisted Living Contract lacked the verbatim "right to designate a representative for certain purposes"	0 950		

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0 950	Continued From page 12 notice required at the time of execution of the contract. On March 09, 2022, at approximately 12:00 p.m., DON-E acknowledged the required verbatim notice was not included in the residents' records. Although a copy of the notice was provided with the required language it was not included in the residents' records. The licensee's Assisted Living Contract policy, dated August 1, 2021, indicated the verbatim notice would be provided to each resident at the time of contract execution. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for resident health, safety, or personal property. This had the potential to affect	0 970		

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0 970	Continued From page 13 all 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: During the entrance conference on March 07, 2022, at approximately 10:30 a.m., the surveyor requested a copy of the facility's assisted living contract. The licensee's Assisted Living Contract included a section for Liability that read, "Provider is not liable to Resident for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by Resident...Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises." On March 09, 2022, at approximately 1:00 p.m., director of nursing (DON)-E confirmed the licensee's assisted living contract included the above content, and stated the same contract was utilized for all residents at the facility. No further information was provided.	0 970		

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0 970	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee to document agreement on the services to be provided for one of six residents (R5) with records reviewed.	01640		

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01640	Continued From page 15 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: R5's signed Service Plan dated November 30, 2021, included services of activities of daily living, assistance with transfers, assistance with ambulation (walking), medication management, and meal tray delivery. R5's Service Plan with print date of March 8, 2022, included services of activities of daily living, trash removal, cleaning assistive devices, assistance with transfers, assistance with ambulation (walking), medication management, blood pressure monitoring, and safety plan for prevention of falls initiated on or after December 30, 2021. R5's record lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provide by licensee after addition of services on or after December 30, 2021. On March 9, 2022, at approximately 1:30 p.m., executive director (ED)-C and director of nursing (DON)-E acknowledged R5's record lacked a current signed and authenticated service plan. DON-E stated it is the licensee's practice to have all updated service plans signed, particularly with changes in fees.	01640		

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01640	Continued From page 16 The licensee's Contents of Service Plans policy dated August 1, 2021, indicated all current service plans would be signed or authenticated by the facility and resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. 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:	01880		

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01880	Continued From page 17 R1 R1 was admitted May 27,2021, and had diagnoses to include diabetes. R1's service plan, dated March 8, 2022, indicated R1 received services to include assistance with medication management. On March 8, 2022, at approximately 07:30 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R1 in his apartment. R1 received Lantus Solostar (insulin in a prefilled pen). The opened insulin pen was on top of a small table in R1's apartment and after ULP-D administered the insulin, the pen was placed back on top of the table, where it was not secure. In addition, the unopened insulin pens were stored in the refrigerator in the resident's apartment, however the insulin was not stored in a securely locked and substantially constructed compartment. R2 R2 was admitted September 9, 2019, and had diagnoses to include diabetes. R2's service plan, signed May 27, 2022, indicated R2 received services to include assistance with medication management. On March 8, 2022, at approximately 08:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2 in his apartment, R2 received insulin Lispro Kwik pen (insulin in a prefilled pens). The opened insulin pen was stored on top of a small table in R2's apartment and after ULP-D administered the insulin, the pen was placed back on top of the table, where it was not secure. In addition, the	01880		

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01880	Continued From page 18 unopened insulin pens were stored in the refrigerator in the resident's apartment, however the insulin was not stored in a securely locked and substantially constructed compartment. On March 9, 2022, at approximately 10:30 a.m., director of nursing (DON)-E acknowledged the open insulin pens were always kept on top of a small table in the residents' apartments and all unopened insulin pens were stored in the refrigerator in the residents' apartments. DON-E stated they will develop a procedure to secure insulin medications. The licensee's " Storage of Medications" policy, dated July 25, 2021, indicated, "When clients are living in a congregate setting or similar senior housing setting, the RN will develop a procedure to secure medications when they are delivered to the building rather than delivered directly to the client in the client's living space. The RN will establish a system that addresses the storage and handling of medications". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an opened insulin pen was dated when opened, and when the pen would expire for two of six residents (R1, R2) 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). Findings include: R1 On March 7, 2022, at approximately 7:30 a.m., unlicensed personnel (ULP)-D was observed to correctly dial up and administer R1's prescribed Lantus Solostar insulin via a pre-filled syringe pen. R1's Lantus insulin pen lacked the date the pen had been opened, and when the pen would expire. On March 7, 2022, at approximately 7:30 a.m., ULP-D confirmed there was no open or expiration date noted on R1's insulin pen device. ULP-D stated the medication labeling process was for the insulin pens to have the date filled out by staff when first taken out of the medication refrigerator for use. Manufacturer's insctructions for Lantus Solostar insulin, dated March 3, 2022, indicated Lantus Solostar insulin pens expire 28 days after	01890		

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01890	Continued From page 20 opening, even if the pen still contains insulin. R2 On March 7, 2022, at approximately 8:00 a.m., unlicensed personnel ULP-D was observed to correctly dial up and administer R2's prescribed Insulin Lispro Kwikpen. R2's Insulin Lispro Kwikpen lacked the date the pen had been opened, and when the pen would expire. On March 7, 2022, at approximately 8:00 a.m., ULP-D confirmed there was no open or expiration date noted on R2's insulin pen device. ULP-D stated the medication labeling process was for the insulin pens to have the date filled out by staff when first taken out of the medication refrigerator for use. Manufacturer's insctructions for Lispro Kwikpen insulin, dated September 27, 2020, indicated Lispro Kwikpen insulin pens expire 28 days after opening, even if the pen still contains insulin. On March 9, 2022, at approximately 1:00 p.m., director of nursing (DON)-E confirmed the process of labeling and dating of all resident insulin pre-filled pens was required when first opened. The licensee's "Medications with Shortened Expiration Dating Once Opened" indicated labeling of insulin pens when opened and discarded after 28 days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01940	Continued From page 21	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management record to include all required content for one of three treatment residents (R6)	01940		

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01940	Continued From page 22 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: R6 admitted to licensee on August 23, 2021. R6's Resident Contract dated February 22, 2022, which included the service plan indicated R6 required assistance to apply and remove TED Hose (thromboembolic stockings or compression socks). R6's treatment management record lacked written instructions and indications when the unlicensed personnel (ULP) would contact the registered nurse (RN) or licensed health professional (LHP). On March 9, 2022, at approximately 1:30 p.m., director of nursing (DON)-E acknowledged R6's treatment management record lacked written instructions and when the ULP would need to contact a RN or LHP. DON-E stated ULPs are trained during orientation on TED hose and when to contact the RN, but the specific instructions were not included in the resident's record. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated July 25, 2021, indicated the required	01940		

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01940	Continued From page 23 content of the treatment management record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management record to include all required content for one of three residents (R6) with treatment 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:	01970		

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ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST MAPLEWOOD, MN 55109

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01970	Continued From page 24 R6 admitted to licensee on August 23, 2021. R6's record included an untitled document dated November 2, 2021, which appeared to be a partial copy of an after-visit summary based on the formatting and appearance of the document compared to resident's other after-visit summaries, from a provider visit indicating R6 wore compression stockings. R6's Resident Contract which included the service plan dated February 22, 2022, indicated R6 required assistance to apply and remove, "TED Hose," (thromboembolic stockings or compression stockings). R6's treatment management record lacked current health care provider's orders for TED Hose. On March 9, 2022, at approximately 1:30 p.m., director of nursing (DON)-E acknowledged R6's treatment management record lacked current orders for R6's TED Hose. DON-E stated the TED Hose orders must have been misplaced, but the TED Hose are noted in the recent after-visit summary from R6's previous provider. R6 had recently changed providers and licensee failed to obtain new orders for the TED Hose from the current provider. The licensee's Documentation of Mediation, Treatment and Therapy Management Services policy dated July 24, 2021, indicated the nurse would obtain prescriptions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27398	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST 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
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 facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigations on and around the property. The hazards identified on the HVA plan must be mitigated to protect the residents from 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 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 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 clients). The findings include:	02040		

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02040	Continued From page 26 On March 9, 2022, between the hours of 9:35 a.m. and 12:05 p.m., survey staff toured the facility with the executive director (ED)-C and the environmental director(D)-G. On March 9, 2022, between the hours of 11:00 a.m. and 12:05 p.m., survey staff toured the two floors of the secured memory care unit located on the north tower of the building. During the tour, survey staff observed the windows in the dining areas and resident bedrooms were not restricted from being opened by residents and/or staff. At approximately 11:10 a.m. while touring resident room 252, staff asked if all the bedroom windows in the memory care unit were constructed similar and the D-G explained that all resident windows were of similar installation. On March 9, 2022, at approximately 12:15 pm, survey staff received the HVA documentation for review, and the following were observed: -The HVA plan lacked complete hazard assessment content on and around the property to protect the dementia care residents from harm including elopement risks from the use of unrestricted windows. Hazard assessments on the HVA plan must include specific safety risks or potential hazard vulnerabilities such as unrestricted windows in resident rooms and common areas throughout the secured memory care unit, the deactivation of the doors by pulling on the blue fire alarm pull stations, deactivation of power doors due to loss of power, accessing the unsecured electrical panels inside each resident room, accessing nearby highways and ponds when elopement occurs, the risks of accessing coffee machine, toaster, and hot food wells in the dining area, and the risks of the misuse of	02040		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SEASONS AT MAPLEWOOD	1670 LEGACY PARKWAY EAST MAPLEWOOD, MN 55109

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02040	Continued From page 27 unsecured portable fire extinguishers or architectural accessories throughout the building. - The HVA plan lacked mitigations documentation including safety measures and/or training provided to the safety risk assessment (vulnerabilities) identified on and around the property to protect all memory care residents from harm. On March 9, 2022, at approximately 2:45 p.m., the ED-C and the D-G acknowledged the above findings during the exit interview. Survey staff explained that all potential safety risks or harm on and around the property must be identified, assessed, and mitigated in the HVA plan documentation and implemented to protect memory care residents from harm. The D-G stated that the licensee was currently working with the HUD for an acceptable solution as HUD had concerns about securing or restricting windows to meet multiple regulations. Staff explained that further conversations will be needed soon for proper resolution to ensure the hazards and mitigations will be addressed and established to minimize harm to the memory care residents. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02040		
02110 SS=C	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:	02110		

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02110	Continued From page 28 (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; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to six of six residents (R1, R2, R3, R4, R5, R6) with records reviewed.	02110		

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02110	Continued From page 29 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 included: Review of R1, R2, R3, R4, R5, and R6's records lacked documentation for receipt of required policies and procedures to be provided at the time of resident move-in to the facility. On March 9, 2022, at approximately 1:00 p.m., director of nursing (DON)-E confirmed there was no evidence the policies and procedures related to dementia care had been provided to the residents or their representatives. DON-E stated they are working on developing the required policies and procedures to be provided at the time of resident move-in to the facility. The licensee lacked policies to include the required policies and procedures to be provided at the time of resident move-in to the facility. No further information 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	02310		

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02310	Continued From page 30 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for four of four residents (R2, R3, R5, R6) 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: R2 On March 8, 2022, at approximately 8:30 a.m., unlicensed personnel (ULP)-B provided R2's morning medications. R2's bed had a siderail on the left side, which was attached to the bed with an adjustable strap connecting the siderail to the bed and looped around the box spring to secure the siderail to the bed. The siderail had a perpendicular extension that proceeded into the bed between the mattress and box spring. The siderail was "U" shape with adjustable extended feet positioned on the floor. The surveyor grasped the siderail and noted the siderail to be secured to the bed and did not move when pulled and pushed on with force. The surveyor did not observe a gap between the siderail and R2's	02310		

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02310	Continued From page 31 mattress. R2 admitted September 09, 2019, with diagnoses including dementia, atrial fibrillation, atherosclerosis, type 2 diabetes, chronic disease, and hypertension. R2's AL Nursing Assessment, dated February 25, 2022, indicated R2 utilized a shower bench/shower chair, and a four wheeled walker. R2's service plan, dated February 27, 2022, indicated R2 received services including medication management and activities of daily living. R2's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails. R3 On March 8, 2022, at approximately 8:30 a.m., the surveyor observed R3's bed had a siderail on the left side, which was not attached to the bed, and the adjustable strap was placed next to siderail but did not secure the siderail to the bed. The siderail was a "U" shape with rails proceeding between the mattress and box spring. The surveyor grasped the siderail and noted the siderail not secured to the bed and did move when pulled and pushed on with force. R3 admitted November 23, 2019, with diagnoses including vascular dementia and hypertension. R3's AL Nursing Assessment, dated February 25, 2022, indicated R3 utilized a manual wheelchair and a shower bench/shower chair. R3's service plan, dated November 29, 2021,	02310		

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02310	Continued From page 32 indicated R3 received services including medication management, and ULPs to assist R3 in and out of bed. R3's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails. R5 On March 8, 2022, at approximately 7:30 a.m., the surveyor observed a bedrail in place on the left side of R5's bed. The bedrail was a in the shape of a "U," with poles extending to the floor and extending into R5's bed between the mattress and box spring. The bedrail was not attached to the bed and was easily moved when the surveyor pulled and pushed the bedrail. R5 stated the bedrail assisted them with bed mobility. R5 admitted May 11, 2018, with diagnoses of Alzheimer's disease, unsteadiness on feet, pain in left knee, and major depressive disorder. R5 Resident Contract, dated November 30, 2021, indicated R5 received services for medication management, activities of daily living, and assistance with transfers. R5's AL Nursing Assessment, dated January 7, 2022, indicated R5 utilized a manual wheelchair, shower bench/shower chair, a sit to stand mechanical lift, and unable was to ambulate. R5's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails. R6 On March 8, 2022, at approximately 7:30 a.m., the surveyor observed a bedrail in place on the	02310		

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02310	Continued From page 33	02310		

left side of R6's bed. The bedrail was a in the shape of a "U," with poles extending into R6's bed between the mattress and box spring. The bedrail was not attached to the bed and was easily moved when the surveyor pulled and pushed the bedrail. R6 stated the bedrail assisted them with bed mobility.

R6 admitted August 23, 2021, with diagnoses of Parkinson's Disease, chronic kidney disease stage III, unsteadiness on feet, and major depressive disorder.

R6's Resident Contract, dated February 22, 2022, indicated R6 received services including medication management, treatment management, activities of daily living, and assistance with transfers.

R6's AL Nursing Assessment, dated January 28, 2022, indicated R6 utilized a manual wheelchair, a shower bench/shower chair, and a four wheeled walker.

R6's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderails.

On March 8, 2022, at approximately 11:00 a.m., director of nursing (DON)-E acknowledged bedrails are in place for R2, R3, R5, and R6. DON-E stated bedrails are provided by residents' family members and the licensee does not provide bedrails. DON-E acknowledged the residents' records would not contain functional ability assessments indicating the presence of bedrails, documentation of bedrail education of risks, or consent for the use of bedrails.

The licensee's Bed Rail policy, dated February

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02310	Continued From page 34 2016, indicated prior to bedrail use, a functional assessment would be completed, provider order obtained, and "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment," available through the Food and Drug Administration would be utilized. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days Immediacy is removed as confirmed by evaluation supervisor communication with licensee on March 9, 2022, however noncompliance remains at a widespread scope, level three (G).	02310		

Minnesota Department of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/08/22*
Time: 12:55:47
Report: 1013221068

Food and Beverage Establishment Inspection Report

Location:
Ecumen Seasons At Maplewood
1670 Legacy Parkway East
Maplewood, MN55109
Ramsey County, 62

Establishment Info:
ID #: 0038091
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517561859
ID #:

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

The following orders were issued during this inspection.

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

PAPER TOWEL DISPENSER WAS JAMMED AND DID NOT DISPENSE TOWELS LOCATED AT THE PREP AREA HAND WASHING SINK. STAFF IDENTIFIED THE SINK AS A HAND WASHING SINK. COMPLY WITH ABOVE RULE. STAFF FIXED THE PAPER TOWEL DISPENSER.

Corrected on Site

4-500 Equipment Maintenance and Operation

4-501.12

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

COOK LINE CUTTING BOARD WAS SCRATCHED AND DISCOLORED. COMPLY WITH ABOVE RULE. CLEAN AND SANITIZE THE CUTTING BOARD OR REPLACE IT.

Comply By: 03/29/22

4-500 Equipment Maintenance and Operation

4-502.13MN

MN Rule 4626.0833 Cut bulk milk dispensing tubes on the diagonal, leaving no more than one inch protruding from the chilled dispensing head.

BULK MILK DISPENSER TUBE WAS CUT STRAIGHT ACROSS LOCATED IN THE KITCHEN. MILK WAS HELD IN THE DISPENSING TUBE. COMPLY WITH ABOVE RULE. STAFF CUT THE DISPENSING TUBE ON THE DIAGONAL.

Corrected on Site

6-200 Physical Facility Design and Construction

6-201.16A

MN Rule 4626.1360A Provide wall and ceiling covering materials that are attached to be easily cleanable.

FRP WAS SCREWED INTO THE WALL LOCATED ABOVE THE DRAIN BOARD ON THE DIRTY DISH SIDE OF THE DISH MACHINE. THE FRP WAS NOT COMPLETELY SEALED TO THE WALL AND WAS NOT CLEANED BEHIND IT. COMPLY WITH ABOVE RULE. CLEAN AND SEAL THE WALL.

Comply By: 03/29/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - Memory Care Service Area
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - Cook Line
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Sanitizer - Prep Area
Violation Issued: No

Hot Water: = at 162 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Salad
Temperature: 41 Degrees Fahrenheit - Location: Tall Cooler
Violation Issued: No

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Milk Dispenser
Violation Issued: No

Process/Item: Chicken Noodle Soup
Temperature: 180 Degrees Fahrenheit - Location: Soup Warmer
Violation Issued: No

Process/Item: Sauerkraut
Temperature: 39 Degrees Fahrenheit - Location: Cold Top Cooler
Violation Issued: No

Process/Item: Corn Beef
Temperature: 37 Degrees Fahrenheit - Location: Cold Top Cooler
Violation Issued: No

Process/Item: Chicken Salad
Temperature: 39 Degrees Fahrenheit - Location: Low Cooler
Violation Issued: No

Type: Full
Date: *03/08/22*
Time: 12:55:47
Report: 1013221068
Ecumen Seasons At Maplewood

Food and Beverage Establishment Inspection Report

Process/Item: Soup
Temperature: 38 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Burgers
Temperature: 39 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Soup
Temperature: 172 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Burger
Temperature: 170 Degrees Fahrenheit - Location: Final Cook Temperature
Violation Issued: No

Process/Item: Sliced Melon
Temperature: 40 Degrees Fahrenheit - Location: Memory Care Refrigerator
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluators S. Hassan and B Mueller.

Discussed final cook temperatures, cleaning, ware washing, temperature control, staff illness policy, cooling, reheating, serving highly susceptible population, sanitizer use, and food handling procedures.

Both refrigerators located in the memory care areas were residential units. Replace with commercial refrigerators that are certified for sanitation by an ANSI accredited company when the units need to be replaced.

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 1013221068 of 03/08/22.

Certified Food Protection Manager: Ronald Fisher

Certification Number: 60803 Expires: 01/09/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Peggy Sandell, Ronald Fisher
Operators

Signed: JM
Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us