November 1, 2023

Licensee
Timber Hills
6305 Burnham Circle
Inver Grove Heights, MN 55076

RE: Project Number(s) SL21981015

Dear Licensee:

On October 18, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 26, 2023, survey were corrected. This follow-up survey verified that the facilty is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 1-866-890-9290

PMB

Electronically Delivered

August 9, 2023

Licensee
Timber Hills
6305 Burnham Circle
Inver Grove Heights, MN 55076

RE: Project Number(s) SL21981015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 26, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH

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 (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 survey:

St - 0 - 0650 - 144g.42 Subd. 8 - Employee Records - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

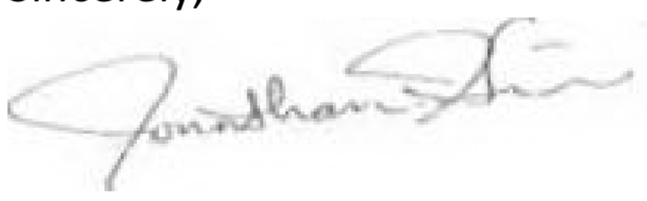
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21981	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER HILLS	6305 BURNHAM CIRCLE INVER GROVE HEIGHTS, MN 55076

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21981015-0 On July 24, 2023, through July 26, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 82 residents receiving services under the provider's Assisted Living/Dementia Care Facility license. On July 25, 2023, at approximately 3:20 p.m. an immediate correction order was written for tag identifier 0650. On July 26, 2023, at 10:01 a.m. the facility submitted a plan to address the immediate order to the surveyor supervisor. At 11:53 a.m. the immediacy was removed from the order; the scope and level remained the same.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 July 24, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 650 SS=I	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	0 650		

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0 650	Continued From page 2 include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a Minnesota Department of Human Services (DHS) NETStudy 2.0 background study and clearance upon hire for three of four employees (unlicensed personnel (ULP)-D, ULP-G, ULP-I). This had the potential to affect all 82 residents at the facility. This resulted in an immediate correction order issued on July 25, 2023, at approximately 3:20 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was	0 650		

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0 650	Continued From page 3 issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 24, 2023, at 11:15 a.m., during entrance conference registered nurse (RN)-A stated the licensed assisted living director (LALD), and clinical nursing supervisor (CNS) were not available for interview. Review of the DHS NETStudy 2.0 Roster on July 25, 2023, at 9:56 a.m., lacked identification ULP-D was affiliated with the licensee's facility and was not on the roster. ULP-D ULP-D was hired on April 13, 2020, to provide services to the licensee's residents. ULP-D employee record included a form titled Sterling Confidential Background Screening Report July 24, 2023. Although the form identified ULP-D's name and information, the employee record lacked the required Department of Human Services (DHS) NETStudy 2.0 background study. On July 24, 2023, at 2:19 p.m., ULP-D was observed to provide R2 with medication administration services. ULP-D was unsupervised during the observation of the medication administration. R2's diagnosis included dementia. R2's service plan dated July 12, 2023, indicated R2 received services to include meals, housekeeping, laundry, toileting, dressing, grooming, bathing and medication administration.	0 650		

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0 650	Continued From page 4 ULP-G ULP-G was hired on June 19, 2022, to provide services to the licensee's residents. ULP-G's employee record included a DHS NETStudy 2.0 background study, however the study was not affiliated with the licensee's facility. On July 25, 2023, at 8:15 a.m., ULP-G and ULP-H were observed assisting R4 with putting his pants on in bed. ULP-H continued to assist R4 into a wheelchair. ULP-H then left the resident apartment and ULP-G continued to provide care without supervision. ULP-G assisted R4 with washing his face, putting on a shirt and administering medications. ULP-G then escorted R4 downstairs to the dining room for breakfast. R4's diagnosis included hypertension. R4's service plan dated June 5, 2023, indicated R4 required assistance with escort services and medication administration. ULP-I ULP-I was hired on June 22, 2021, to provide services to the licensee's residents and was noted on the licensee's home health aide/registered nurse (HHA/RN) schedule to have worked on July 10, 2023. ULP-I employee record included a form titled Sterling Confidential Background Screening Report dated May 22, 2021. Although the form identified ULP-I's name and information, the employee record lacked the required DHS NETStudy 2.0 background study. On July 25, 2023, at 9:30 a.m., during an interview, human resources director (HRD)-C, identified as the sensitive information person (SIP), stated she was only able to find a background clearance screening report from Sterling for unlicensed personnel (ULP)-D.	0 650		

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0 650	Continued From page 5 HRD-C also stated the DHS screening through NETStudy 2.0 were submitted at the same time as the Sterling report. - at 9:50 a.m. surveyor observed HRD-C open the NETStudy 2.0 website application on the computer screen in HRD-C's office. ULP-D verified with HRD-C, to not be on the facility Net Study 2.0 roster. HRD-C stated she does not know why ULP-D was not showing up on the roster. With surveyor present, HRD-C made three unsuccessful attempts to reach helpdesk support at NETStudy 2.0. - at 10:30 a.m., HRD-C stated, she had registered ULP-D in NETStudy 2.0 again and planned to have ULP-D get background study process and fingerprinted right away, possibly before ULP-D is scheduled to work this afternoon. - at 11:55 a.m., HRD-C stated, she was the (SIP) for the facility, and was responsible for both the Sterling Confidential Background Screening Report, and the NETStudy 2.0 oversight.. HRD-C indicated, the process for background screening is to have the Sterling report completed upon hire before employee arrived to the facility, and the NETStudy 2.0 portion was completed with new hires when they onboard with HRD-C at the facility. HRD-C further stated ULP-G had transferred to the current facility after the licensee had purchased the facility ULP-G was affiliated with on the background study clearance. HRD-C stated she would change the affiliation to reflect the correct location. - at 1:15 p.m., HRD-C stated, ULP-I was another transfer from another facility, and all she was able to find was the Sterling Confidential Background Screening Report dated May 22, 2021. -at 1:45 p.m., surveyor asked registered nurse (RN)-A for the last three months of the staffing schedule to be provided (no schedules were	0 650		

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0 650	Continued From page 6 provided at the time of the immediate order). - at 1:50 p.m., scheduler (S)-K stated, ULP-I was an on-call employee and last worked July 10, 2023. S-K further stated ULP-I was no longer in orientation and would not have been supervised while working. On July 25, 2023, at 11:55 a.m., HRD-C provided surveyor with the licensee's Background Check policy dated April 13, 2018. The policy indicated the "[Licensee] is committed to providing safe and secure housing, medical care, and related services for the elderly. [Licensee] will not employ anyone who poses an unacceptable risk to the safety or well-being of its residents, employees, or other members of its community," but lacked information regarding the completion of a Minnesota Department of Human Services (DHS) NETStudy 2.0 background study, clearance upon hire and did not address how staff would be supervised while waiting for NETStudy eligibility results. The MN Department of Health Assisted Living Resources & Frequently-Asked Questions (FAQs) webpage dated June 21, 2023 included the following FAQ for background study: "Direct contact: means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program. If an organization has multiple facilities, does a separate background study need to be submitted in NETStudy 2.0 for each HFID? If you have an existing background study for someone at one facility, you can affiliate the person ' s background study to another facility if the Sensitive Information Person (SIP) is the same." What is 'affiliation'?	0 650		

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0 650	Continued From page 7 Affiliation is the process of adding a subject with a completed study onto another HFID ' s roster without submitting a new study. For instructions on how to add an affiliation record when permissible, refer to the Help section in NETStudy 2.0: NETStudy 2.0 User Manual, page 79 or training video Roster part 2." Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD OF CORRECTION: Immediate On July 26, 2023, at 10:01 a.m. the facility	0 650		

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0 650	Continued From page 8 submitted a plan to address the immediate order to the surveyor supervisor. At 11:52 a.m. immediacy was removed from the order; the scope and level remained the same.	0 650		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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 some of the 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 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: On 07/25/2023, from approximately 11:30 a.m. to 12:05 p.m., survey staff toured the facility with	0 800		

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0 800	Continued From page 9 Maintenance Director (MD)-J. During the facility tour, survey staff observed and verified the following maintenance issues. The magnetic door holder was broken off the metal fire safety door in the north corridor of memory care and was propped open with a wooden wedge. This prevents the fire safety door to release when the fire alarms are actuated. Ceiling tiles in the entrance and laundry room of memory care wing has several water stains. MD-J verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (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	0 810		

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(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
0 810	Continued From page 10 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21981	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER HILLS	6305 BURNHAM CIRCLE INVER GROVE HEIGHTS, MN 55076

(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
0 810	Continued From page 11 July 25, 2023, at approximately 12:10 p.m. with Maintenance Director (MD)-J, on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have all the employee actions to be taken in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have all the fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the evacuation plan did not include 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. During interview, MD-J, verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21981	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER HILLS	6305 BURNHAM CIRCLE INVER GROVE HEIGHTS, MN 55076

(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
01620	Continued From page 12 (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after admission for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: 14-DAY	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21981	A. BUILDING: _____ B. WING _____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBER HILLS	6305 BURNHAM CIRCLE INVER GROVE HEIGHTS, MN 55076

(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
01620	Continued From page 13 R1 R1 was admitted April 24, 2023, and received services including assistance with meals, housekeeping, laundry, showers, compression stockings, and medication administration. R1's record included an initial comprehensive nursing assessment, dated April 28, 2023, and a subsequent RN comprehensive nursing assessment, dated July 11, 2023, 74 days after the start of services. On July 26, 2023, at 10:30 a.m., RN-E stated she was instructed if both the pre-move in, and initial RN assessment were completed, the 14-day RN assessment was not required. RN-E stated the electronic medical record indicated that R1's 14-day RN assessment had not been completed. The licensee's MN AL Nursing Assessment policy, updated May 3, 2022, indicated, "7. An RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: a. Initial Assessment; b. 14-day assessment, completed up to 14-days after start of services and will include: i. An evaluation of the resident's medication management services and the resident's medications and complete a medication management plan if the organization provides services related to the resident's medications; ii. An evaluation of the resident's treatments, if any and complete the treatment and therapy management plan if the organization provides services related to the resident's treatments; iii. Communication of any new problems or concerns to the resident's physician or health care providers;	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21981	A. BUILDING: _____ B. WING _____	07/26/2023

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TIMBER HILLS	6305 BURNHAM CIRCLE INVER GROVE HEIGHTS, MN 55076

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01620	Continued From page 14 c. Ongoing assessment: completed periodically but no less than every 90-days; and d. Change in resident condition." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Type: Full
Date: *07/24/23*
Time: 15:04:47
Report: 1021231224

Food and Beverage Establishment Inspection Report

Location:
Timber Hills
6305 Burnham Circle
Inver Grove Heights, MN55077
Dakota County, 19

Establishment Info:
ID #: 0016499
Risk: High
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:
PHM - Inver Grove, Inc.

Phone #: 6515522800
ID #: 18497

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.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN THE MAIN KITCHEN DISH MACHINE AND IN THE MEMORY CARE DISH MACHINE. PROVIDE.

Comply By: 08/01/23

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

THE CAN OPENER BLADE CONTAINS ACCUMULATION OF DRIED FOOD DEBRIS. DIRECTOR TOOK THE CAN OPENER TO WASH, RINSE AND SANITIZE DURING INSPECTION. CORRECTED ON-SITE. CLEAN AND SANITIZE CAN OPENER AFTER EACH USE.

Comply By: 07/24/23

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

3-304.12F

MN Rule 4626.0275F Discontinue storing food preparation or dispensing utensils in a container of water that is not maintained at 135 degrees F (57 degrees C) and not cleaned when empty.

ICE CREAM SCOOP FOUND STORED INSIDE A CONTAINER WITH STANDING WATER. THE WATER TEMPERATURE MEASURED BELOW 135F. DIRECTOR REMOVED CONTAINER WITH STANDING WATER DURING INSPECTION. CORRECTED ON-SITE. COMPLY WITH RULE ABOVE.

Comply By: 07/24/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE AMBIENT TEMPERATURE OF THE MCCALL UPRIGHT COOLER IN THE SERVING KITCHEN MEASURED 46F AND LATER 42F. ALL TCS FOODS IN THAT COOLER WERE MOVED TO THE WALK-IN COOLER DURING INSPECTION. STAFF WILL MONITOR COOLER. SEE COMMENTS.

Comply By: 07/24/23

4-600 Cleaning Equipment and Utensils

4-602.11E

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

THE INSIDE TOP PART OF THE ICE MACHINE IN THE SERVING KITCHEN CONTAINS ACCUMULATION OF HARD WATER AND SLIMY RESIDUE. CLEAN AND SANITIZE ICE MACHINE.

Comply By: 07/26/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

WET MOP FOUND SITTING IN THE MOP SINK. DIRECTOR MOVED THE WET MOP TO HANG ABOVE THE MOP SINK. CORRECTED ON-SITE.

Comply By: 07/24/23

Surface and Equipment Sanitizers

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit
Location: SANI BUCKET, SERVING KITCHEN
Violation Issued: No

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit
Location: SANI BUCKET, MAIN KITCHEN
Violation Issued: No

Final Utensil Surface Temp: = at 165 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Sink & Surface Sanitizer: = 700PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 172 Degrees Fahrenheit - Location: CLAM CHOWDER, HOT WELLS
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: Degrees Fahrenheit - Location: MCCALL UPRIGHT COOLER, SERVING KITCHEN
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: CUT MELON - MCCALL UPRIGHT COOLER *MOVED TO WALK-IN COOLER
Violation Issued: No

Process/Item: Cooling
Temperature: 43 Degrees Fahrenheit - Location: MILK - MCCALL UPRIGHT COOLER, COOLING FROM AMBIENT *MOVED TO WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: GRILLED CHICKEN - TRUE UPRIGHT COOLER
Violation Issued: No

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

Process/Item: Cooling
Temperature: 54 Degrees Fahrenheit - Location: COOKED SAUSAGES - TRUE UPRIGHT COOLER, COOLING FOR 3 HOURS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 182 Degrees Fahrenheit - Location: MASHED POTATOES - ALTO SHAAM WARMER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: CHILI - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: CUT MELON - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: STRAWBERRY FIELDS SALAD - DELI DISPLAY COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: EGG SALAD SANDWICH - DELI DISPLAY COOLER

Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - MARKET TRUE UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: MILK - MEMORY CARE REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	2	4

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH CULINARY DIRECTOR, SAMUEL MILLER AND HEALTH REGULATION DIVISION NURSE EVALUATORS, TAMMY CARLSON AND DEDE HINNENDAEL.

CONTINUATION OF MN Rule 4626.0735AB
DO NOT STORE TCS FOODS IN THE MCCALL UPRIGHT COOLER UNTIL IT REACHES 41F AND BELOW. IF COOLER DOES NOT REACH 41F AND BELOW THEN IT NEEDS TO BE SERVICED.

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 1021231224 of 07/24/23.

Certified Food Protection Manager: MACAYLA M. CATES

Certification Number: FM107875 Expires: 07/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
SAMUEL MILLER
CULINARY DIRECTOR

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us