Electronically Delivered

May 2, 2023

Licensee
Havenwood Of Burnsville
14401 Grand Avenue
Burnsville, MN 55306

RE: Project Number(s) SL35795015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted no 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 MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35795	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF BURNSVILLE	14401 GRAND AVENUE BURNSVILLE, MN 55306

(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: SL#35795015 On April 10, 2023, through April 12, 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 52 active residents; 47 receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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). Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 11, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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;	0 810		

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0 810	Continued From page 2 (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 the interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. 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	0 810		

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0 810	Continued From page 3 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: An interview and record review were conducted on April 12, 2023, at approximately 10:00 a.m. with the Licensed Assisted Living Director (LALD)-A and the Maintenance Director (DOM)-F on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. On the facility tour with the LALD-A and DOM-F on April 12, 2023, at approximately 10:00 a.m., it was observed the following items were observed: It was observed that the posted fire safety and evacuation plan on all four floors did not have the number of resident rooms. It was observed that the posted fire safety and evacuation plan on level one was not accurate depictions of the egress route and were not matched to the installed overhead exit signage location. In the posted level one fire safety and evacuation plan, it was observed that the exit egress route notation from the main corridor was shown through the fitness room. But the fitness room did not have an overhead exit sign at the corridor side door and did not have an overhead exit sign at the exterior door. This deficient condition was visually verified by LALD-A and DOM-F accompanying the tour.	0 810		

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0 810	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case	01060		

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01060	Continued From page 5 manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for two of two residents (R4, R5). 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: R4 was admitted to the facility on April 1, 2020, and began receiving assisted living services on August 1, 2021. R4's Service Plan Agreement dated April 10, 2023, indicated R4 received services which included bathing, dressing, housekeeping, laundry, medication administration, blood glucose monitoring, and oxygen assistance. R4's progress notes revealed the resident had	01060		

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01060	Continued From page 6 been hospitalized during the following dates: - December 21, 2022, to December 27, 2022, for COVID-19 and hypoxia (a below-normal level of oxygen in the blood). - January 20, 2023, to January 29, 2023, due to hypoxia. - February 2, 2023, to February 21, 2023, due to hypoxia. On April 11, 2023, at 1:55 p.m. licensed assisted living director (LALD)-A provided the required transfer notices for R4's last two hospitalizations (January 20, 2023, and February 2, 2023) and stated they had not notified the ombudsman at that time but will moving forward as were notified of this requirement from a sister facility. The surveyor reviewed the Notification of Emergency Relocation forms for R4 which indicated the notification was made to the resident and not to the resident's legal and/or designated representative. The surveyor asked if they would usually contact the legal/designated representative, and LALD-A said it would "depend", and then they would email it to them. LALD-A further stated they would not know whether the legal/designated representative was actually notified. R5 R4 began receiving assisted living services on January 5, 2023. R5's Service Plan dated April 10, 2023, indicated R5 received services which included bathing, dressing, transfers, toileting, laundry, housekeeping, and medication administration. R5's progress note revealed the resident was hospitalized on January 9, 2023, for increased weakness, and was diagnosed with COVID-19	01060		

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01060	Continued From page 7 and pneumonia. R5 was hospitalized until January 19, 2023, and then was transferred to a transitional care unit for therapy and to regain strength. R5 returned to the assisted living with dementia care facility on February 7, 2023. On April 12, 2023, at 9:00 a.m. LALD-A confirmed R5 had been hospitalized shortly after moving into the facility. LALD-A further confirmed R5's record did not include evidence of a relocation notice or notification to the ombudsman. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication	01760		

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01760	Continued From page 8 procedures were followed during medication administration for 1 of 1 resident (R4) who received insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included diabetes. R4's Service Plan Agreement dated April 10, 2023, indicated R4 received services which included medication administration and blood glucose monitoring. R4's physician order dated April 6, 2023, included Humalog (insulin) - inject 10 units at breakfast, 12 units at lunch, and 10 units at dinner. Hold if BS (blood sugar) less than 80. On April 11, 2023, at 7:55 a.m. unlicensed personnel (ULP)-D was observed setting up R4's medication. While preparing R4's Humulin insulin Kwikpen, the surveyor noted there was no date when opened on the pen. When viewing the label on the insulin pen it, was noted to read "inject 14 units subq (subcutaneously/under the skin) at lunch. ULP-D confirmed the insulin pen was not dated when opened and should have been. ULP-D further confirmed R4's insulin order had recently changed, and they always go by the order in the eMAR (electronic medication	01760		

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01760	Continued From page 9 administration record). ULP-D confirmed the label was incorrect and when an order changed, they would usually put a sticker on the label to refer to the MAR. ULP-D then brought R4's medications, including the undated insulin pen, to R4's apartment and administered to the resident. On April 11, 2023, at 11:32 a.m., registered nurse (RN)-G confirmed insulin needed to be dated when opened and would expect the ULP to contact the nurse if it hadn't been prior to administering. RN-G stated she would obtain a new insulin pen for R4 and would put a sticker on it to refer to the MAR as the label would still be incorrect. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy February 10, 2022, indicated: "2. Medications, treatment, and therapy always need to be administered according to the "6 Rights" a. Right person b. Right medication, treatment, or therapy c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc.) f. right chart/record to document that the medication, treatment and therapy are taken." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 10 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of one resident (R4) with insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included diabetes. R4's Service Plan Agreement dated April 10, 2023, indicated R4 received services which included medication administration and blood glucose monitoring. R4's physician order dated April 6, 2023, included Humalog (insulin) - inject 10 units at breakfast, 12 units at lunch, and 10 units at dinner. Hold if BS (blood sugar) less than 80. On April 11, 2023, at 7:55 a.m. unlicensed	01890		

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01890	Continued From page 11	01890		

personnel (ULP)-D was observed setting up medication to administer for R4. While preparing R4's Humulin insulin Kwikpen, the surveyor noted there was no date when opened on the pen. When viewing the label on the insulin pen, it was noted to read "inject 14 units subq (subcutaneously/under the skin) at lunch. ULP-D confirmed the insulin pen was not dated when opened and should have been. ULP-D further confirmed R4's insulin order had recently changed, and they always go by the order in the eMAR (electronic medication administration record). ULP-D confirmed the label was incorrect and when an order changed, they would usually put a sticker on the label to refer to the MAR. ULP-D then brought R4's medications including the undated insulin pen to R4's apartment and administered to the resident.

On April 11, 2023, at 11:32 a.m. registered nurse (RN)-G confirmed insulin needed to be dated when opened and would expect the ULP to contact the nurse if it hadn't been prior to administering. RN-G stated she would obtain a new insulin pen for R4 and would put a sticker on it to refer to the MAR as the label would still be incorrect.

The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy February 10, 2022, indicated:
"2. Medications, treatment, and therapy always need to be administered according to the "6 Rights"
a. Right person
b. Right medication, treatment, or therapy
c. Right time
d. Right route (by mouth, eye drops, to the skin, etc.)
e. Right dose (how many milligrams, drops,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF BURNSVILLE	14401 GRAND AVENUE BURNSVILLE, MN 55306

(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
01890	Continued From page 12 etc.) f. right chart/record to document that the medication, treatment and therapy are taken." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
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	01940		

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01940	Continued From page 13 treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized treatment plan with the required content for one of one resident (R2) receiving oxygen. 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: R2 started receiving services March 31, 2023, with a diagnosis including malignant neoplasm of the right lung. On April 11, 2023, at 11:00 a.m. the surveyor observed R2 receiving oxygen through a nasal cannula. R2's physician order dated January 18, 2023, included an order for oxygen at 2-3 liters by nasal cannula. R2's comprehensive assessment dated March 17, 2023, indicated R2 requires occasional physical assistance from staff adjusting nasal cannula/mask, and or refilling portable tank up to	01940		

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	35795	A. BUILDING: _____ B. WING _____	04/12/2023

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01940	Continued From page 14 twice daily. R2's service plan dated March 29, 2023, lacked evidence R2 was receiving oxygen. R2's record lacked specific written instructions for how many liters of oxygen should be applied. On April 11, 2023, at 12:00 p.m. the licensed assisted living director (LALD)-A confirmed R2's service plan lacked specific instructions for the unlicensed personnel (ULP) on what liter flow of oxygen to use. The licensee's Administration of Medication, Treatment, and Therapy by Unlicensed Personnel policy, dated February 10, 2022, indicated the registered nurse (RN) may delegate to unlicensed personnel the task of providing assistance with self-administration of medications, treatment, and therapy if the RN has developed written, specific instruction for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations;	02170		

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	35795	A. BUILDING: _____ B. WING _____	04/12/2023

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02170	Continued From page 15 (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation, for one of one resident (R4) who received services in the memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02170	Continued From page 16	02170		

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).

The findings include:

The licensee held an assisted living with dementia care license, effective February 17, 2023.

R4's diagnoses included diabetes with diabetic neuropathy, coronary artery disease, and acute kidney failure.

R4's Service Plan Agreement dated April 10, 2023, indicated R4 received services which included bathing, dressing, housekeeping, laundry, medication administration, blood glucose monitoring, and oxygen assistance.

On April 11, 2023, at 7:55 a.m. unlicensed personnel (ULP)-D was observed administering medication to R4.

R4's Interest Inventory form reviewed/updated April 6, 2023, indicated past and current interests, and adaptations necessary for the resident to participate. R4's record lacked the following:
- current abilities and skills
- emotional and social needs and patterns
- physical abilities and limitations
- identification of activities for behavioral interventions.

R4's record did not include evidence of an individualized activity plan based on the resident's

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02170	Continued From page 17 activity assessment. On April 12, 2023, at 12:58 p.m. life enrichment manager for memory care (LEMMC)-E provided the surveyor with the April 2023, activity calendar and had highlighted the activities anticipated that R4 would be interested in. LEMMC-E confirmed there was no other activity plan for R4 other than the monthly activity calendar. On April 12, 2023, at 1:20 p.m. licensed assisted living director (LALD)-A stated the memory care monthly activity calendar would be considered the activity plan for residents on the memory care unit. LALD-A confirmed the monthly activity calendar was not individualized specifically for R4. The licensee's Description of Life Enrichment Programs and How Activities are Implemented in ALDC (assisted living with dementia care) policy indicated: 1. Each resident receiving assisted living services will be evaluated for activities. The evaluation must include: a. Past and current interest s b. Current abilities and skills c. Emotional and social needs and patterns d. Physical abilities and limitations e. Adaptations necessary for the resident to participate, and f. Identification of activities for behavioral interventions 4. An individualized activity plan will be developed for those receiving assisted living services based on their activity evaluation. The plan will reflect the resident's activity preferences and needs. No further information was provided.	02170		

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02170	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *04/11/23*
Time: 15:09:19
Report: 1018231069

Food and Beverage Establishment Inspection Report

Location:
Havenwood Of Burnsville Al
14401 Grand Avenue
Burnsville, MN55306
Dakota County, 19

Establishment Info:
ID #: 0038407
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522065700
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.

4-500 Equipment Maintenance and Operation

4-501.114E ** Priority 1 **

MN Rule 4626.0805E Provide and maintain a chemical sanitizer other than chlorine, iodine or a quaternary ammonium compound according to the US EPA registered label use instructions.

SMART-POWER SANITIZER FOR 3 COMPARTMENT SINK OBSERVED TO BE AT 0PPM. COMPLY WITH RULE.

Comply By: 04/11/23

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT CURRENTLY ONLY HAS SERVSAFE CERTIFICATE. DISCUSSED THE CFPM REQUIREMENT WITH MANAGER.

Comply By: 06/30/23

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.

KITCHEN MANAGER STATED THAT SODA NOZZLES FOR THE SODA MACHINE ARE

SOAKED IN SODA WATER OVER NIGHT. DISCUSSED THE NEED FOR A FULL WASH-RINSE-SANITIZE PROCEDURE DAILY WITH THESE ITEMS.

Comply By: 04/11/23

Surface and Equipment Sanitizers

SMARTPOWER: = 0PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: Yes

Hot Water: = at 174 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ TURKEY
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ TOMATO
Temperature: 39 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ BEEF
Temperature: 37 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding/ BEEF
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Holding/ COLESLAW
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

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

Process/Item: Hot Holding/ SOUP
Temperature: 170 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

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

INSPECTION CONDUCTED WITH TRACEY FEARON (MDH) PRESENT

DISCUSSED EMPLOYEE ILLNESS AND VIEWED ILLNESS POLICY.

ESTABLISHMENT USES ONLY PASTEURIZED EGGS.

OBSERVED APPROPRIATE COOLING AND DATE MARKING PROCEDURES.

DISCUSSED PEST CONTROL MANAGEMENT.

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 1018231069 of 04/11/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
JULIE PITSENBARGER
MANAGER

Signed:_____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us