DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 5, 2022

Administrator
Woodcrest Assisted Living
1201 Ridgeview Terrace Northeast
Alexandria, MN 56308

RE: Project Number SL30701015

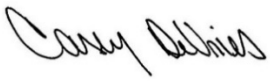
Dear Administrator:

On August 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 8, 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,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

Electronically Delivered

July 6, 2022

Administrator
Woodcrest Assisted Living
1201 Ridgeview Terrace Northeast
Alexandria, MN 56308

RE: Project Number SL30701015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 8, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

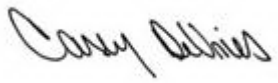
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



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HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30701	A. BUILDING: _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST ASSISTED LIVING	1201 RIDGEVIEW TERRACE NE ALEXANDRIA, MN 56308

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30701015 On June 6, 2022, through June 8, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were seven residents receiving services under the Assisted Living with Dementia 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 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 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During entrance conference on June 6, 2022, at approximately 10:45 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they had reviewed the current assisted living regulations. Additionally, CNS-B	0 250		

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0 250	Continued From page 3 stated, "some of it I may know. I know she [LALD] would know all of it." The licensee failed to ensure the following policies and procedures were in place and kept current: - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - reminders for medications, treatments, or exercises, if provided; - medication and treatment management; - delegation of tasks by registered nurses and licensed health professionals; and - supervision of registered nurses and licensed health professionals. On June 7, 2022, at approximately 1:40 p.m., LALD-A verified the licensee did not have the policies listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;	0 470		

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0 470	Continued From page 4 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a staffing plan to determine staffing levels to meet the needs of all residents and to ensure the plan was implemented and posted as required. This had the potential to affect all seven residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 470		

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0 470	Continued From page 5 are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia facility license and was licensed for a capacity of ten residents, with a current census of seven residents. During the facility tour on June 6, 2022, at approximately 11:15 a.m., licensed assisted living director (LALD)-A confirmed the licensee employed one licensed personnel and eight unlicensed personnel at the survey location. LALD-A stated she wrote the staff schedule once monthly. LALD-A stated there was no "matrix or plan", scheduling was based on licensee's census and resident needs. On June 6, 2022, at approximately 11:20 a.m., clinical nurse supervisor (CNS)-B stated "she [LALD] takes care of that". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 480		

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0 480	Continued From page 6 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all seven residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 6, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 510	Continued From page 7	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff wore recommended personal protective equipment while working in the facility. The deficient practice had the potential to affect all residents, employees 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). The findings include:	0 510		

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0 510	Continued From page 8 On June 6, 2022, at 10:30 a.m., the surveyor was greeted at the entrance door of the facility by licensed assisted living director (LALD)-A. The entrance door was located in the main living area of the facility with two residents present in the room. LALD-A was not wearing a face mask or protective eyewear. On June 6, 2022, at 10:40 a.m., during the entrance conference, the surveyor observed LALD-A and clinical nurse supervisor (CNS)-B not wearing eye protection or protective masks. The surveyor discussed the need for all employees to be wearing medical grade masks and eye protection with LALD-A and CNS-B. On June 6, 2022, at approximately 11:15 a.m., during a tour of the facility with LALD-A, the surveyor observed LALD-A not wearing a face mask or protective eyewear throughout the tour. During the tour, the surveyor observed unlicensed personnel (ULP)-C assisting residents in the main living area with no protective eyewear or mask. On June 6, 2022, at approximately 12:00 p.m., the surveyor observed ULP-C and CNS-B provide meal setup assistance for four residents in the dining room wearing no face mask or protective eyewear. On June 6, 2022, at approximately 1:26 p.m., the surveyor observed ULP-C administer medications to R1 without the use of a face mask or protective eyewear. The surveyor asked how long it had been that staff had not used personal protective equipment (PPE) and ULP-C stated "it's been a couple weeks" since [LALD-A] directed staff that PPE was no longer required.	0 510		

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0 510	Continued From page 9 On June 6, 2022, at approximately 2:10 p.m., LALD-A confirmed staff had not worn face masks or protective eyewear for a couple weeks and additionally stated "I was told by our county we didn't need to wear PPE anymore. It's very confusing who we should listen to. I could lose five staff if I make them wear masks and eyewear." The Minnesota Department of Health (MDH) document titled COVID-19 Personal Protective Equipment (PPE) and Source Control Grid, dated April 7, 2022, directed healthcare workers with face-to-face contact with residents to wear a medical grade, well-fitting mask and eye protection during periods of high community transmission. On June 6, 2022, at 2:38 p.m., the surveyor and LALD-A confirmed the Centers for Disease Control and Prevention (CDC) Covid-19 Data Tracker website indicated Covid transmission levels were high within the county the facility is located. The surveyor provided the link to LALD-A and CNS-B. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of	0 620		

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0 620	Continued From page 10 maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an allegation of suspected maltreatment was reported to Minnesota Adult Abuse Reporting Center (MARRC) for one of one resident (R2) who eloped from the facility. 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 was admitted to the licensee on December 27, 2021, with a diagnosis of dementia. R2's Assisted Living Vulnerability/Risk Assessment and Abuse Prevention Plan (IAPP) dated December 27, 2021, indicated R2 was vulnerable in the area of grooming, hygiene, dressing, medications, needed assistance with the use of a phone, was unable to and unaware of ability to exercise judgement regarding or consent to sexual activity, inability to identify potentially dangerous situations, inability to deal with verbally or aggressive persons, lack of communication skills, inappropriate social	0 620		

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	30701	A. BUILDING: _____ B. WING _____	06/08/2022

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0 620	Continued From page 11 behaviors, unaware of inclement weather hazards, does not recognize or protect self from potential safety risks, does not recognize or protect self against potentially abusive/harmful situations and does not respond to emergency situations or warning devices and impaired judgement/actions when agitated, anxious or upset. R2's service plan dated December 27, 2021, indicated R2 received assistance with appointments, transportation, money management, socialization, dressing, grooming, bathing, meal setup, medication management, redirection and reorientation. On June 6, 2022, at 10:55 a.m., during the entrance conference, the surveyor requested copies of all MAARC reports the licensee filed since February 2022, as well as any documented complaints or incidents since February 2022. On June 6, 2022, at approximately 10:55 a.m., licensed assisted living director (LALD)-A stated there were no Minnesota Adult Abuse Reporting Center (MAARC) reports filed, but the facility had an elopement incident in February 2022. R2's incident report dated February 25, 2022, stated R2 was seen on camera leaving the facility at approximately 9:09 a.m., and was found by law enforcement at a four-way intersection and was returned to the facility 9:50 a.m. The determination on the incident report indicated the door alarm was inactive at the time of the incident and staff had failed to perform hourly safety checks on the alarms. The registered nurse (RN) on call was notified as well as R2's family at the time of incident.	0 620		

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0 620	Continued From page 12 During interview on June 7, 2022, at approximately 10:52 a.m., LALD-A stated she did not believe a MAARC report was indicated as LALD-A stated she was told by MAARC "that it was up to us if we wanted to file a report or not. There was no harm to the resident and he eloped all the time from his last facility." LALD-A was unable to provide documentation that a phone call had been made to MAARC. The licensee's Interventions For Residents at Risk of Wandering and/or Elopement policy dated January 1, 2019, indicated the RN would report the incident to the Common Entry Point immediately (within 24 hours) reassess the resident and determine if changes were needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=E	144G.42 Subd. 6 (b) 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	0 630		

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0 630	Continued From page 13 by: Based on observation, interview and record review, the licensee failed to develop an individual abuse prevention plan with the required content for two of two 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 client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included type 2 diabetes, morbid obesity, atherosclerotic heart disease and peripheral vascular disease. R1's service plan dated September 20, 2021, indicated R1 received services including medication administration and assistance with bathing, dressing, grooming, toileting, ambulation, transfers, housekeeping and laundry. On June 7, 2022, at approximately 12:05 p.m., the surveyor observed unlicensed personnel (ULP)-C conduct a blood glucose (sugar) test with a result of 70 milligrams per deciliter (mg/dl). R1's Vulnerability Assessment dated September 9, 2021, identified areas of vulnerability with ambulation, history of choking, incontinence, communication, inability to identify potentially	0 630		

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0 630	Continued From page 14 dangerous situations and lack of ability to protect self from a verbally abusive individual. R1's individual abuse prevention plan did not include: - the resident's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R2 R2's diagnoses included dementia, amnesia, malignant tumor of the prostate and conduction disorder of the heart. R2's service plan dated December 27, 2021, indicated R2 received services including medication administration, dressing, grooming, bathing, meal setup, behavior monitoring, laundry and housekeeping. On June 7, 2022, at approximately 12:24 p.m., the surveyor observed ULP-C assist R2 with meal setup and food cutting. R2's Vulnerability Assessment dated December 27, 2021, identified areas of vulnerability with inability to exercise judgement regarding or consent to sexual activity, inability to identify potentially dangerous situations, inability to deal with verbally or aggressive persons, lack of communication skills, inappropriate social behaviors, unaware of inclement weather hazards, does not recognize or protect self from potential safety risks, does not recognize or protect self against potentially abusive/harmful situations and does not respond to emergency situations or warning devices and impaired judgement/actions when agitated, anxious or	0 630		

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0 630	Continued From page 15 upset. R2's individual abuse prevention plan did not include: - the resident's risk of abusing other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On June 7, 2022, at 2:55 p.m., clinical nurse supervisor (CNS)-B confirmed R1 and R2's Individual Abuse Prevention Plan (IAPP) did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 16 (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and post an emergency preparedness plan prominently. This had the potential to affect all seven residents receiving services under the assisted living with dementia care license. 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). The findings include: During the entrance conference on June 6, 2022, at approximately 10:45 a.m., the surveyor requested to view the licensee's emergency preparedness plan, which was provided to and	0 680		

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0 680	Continued From page 17 later reviewed by the surveyor. The licensee's plan did not include the following required content: - development of policies/procedures to address: - evacuation plan (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; - the facilities role in providing care and treatment at alternative sites. - emergency preparedness training and testing program; and - emergency preparedness testing/annual testing requirements. On June 7, 2022, at approximately 3:50 p.m., licensed assisted living director (LALD)-A confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. Additionally, LALD-A stated the Appendix-Z requirements were "being worked on. It is started, I just haven't been able to get it finished." The licensee's Disaster policy dated January 1, 2019, indicated the facility would develop facility specific disaster policies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 680		

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0 780	Continued From page 18	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in some of the resident's bedrooms. In addition, the facility failed to provide smoke alarms that were interconnected in some resident's bedrooms and in a basement bedroom. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 19 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 issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On June 7, 2022, between 10:05 a.m. and 11:15 a.m., survey staff toured the facility with maintenance Director (MD)-D. During the facility tour, survey staff observed the following: 1. Smoke alarms in resident's bedrooms #1, #2, #3, and #4 were not interconnected so that actuation of one alarm will cause all alarms in the dwelling to actuate. 2. Resident room #3 and one of the basement bedrooms did not have smoke alarms provided. 3. The smoke alarm in room #8 was not working properly. MD-D verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 800		

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0 800	Continued From page 20 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 deficient condition had the ability to affect a limited number of 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 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 June 7, 2022, from approximately 9:57 a.m. to 11:15 a.m., survey staff toured the facility with Maintenance Director (MD)-D. During the facility tour, survey staff observed and verified the following maintenance issues: 1. No bathroom fan was provided in the resident's main bathroom. 2. The window crank in resident room #3 was not working properly. MD-D verbally confirmed survey staff observations during the facility tour. No further information provided.	0 800		

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0 800	Continued From page 21 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 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.	0 810		

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0 810	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On June 07, 2022, from approximately 11:15 a.m. to 11:40 a.m., survey staff reviewed facility records with Licensed Assisted Living Director (LALD)-A. During the review, survey staff observed the facility fire safety and evacuation plan documentation was requested and was noted to lack the following: Documentation of required employee evacuation drills did not show drills being done every other month. The schedule and required records on training of employees on fire safety and evacuation. The schedule and required records on training of residents who can assist their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, relocation. Fire safety and evacuation plans shall be always readily available within the facility. On June 07, 2022, at approximately 11:40 a.m.	0 810		

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0 810	Continued From page 23 LALD-A were not able to provide the information listed above as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all facility physical elements, including, the minimum size egress windows on the second-floor resident room, do not create a distinct hazard to residents and staff. This affected resident room #5. 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	0 820		

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0 820	Continued From page 24 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On June 07, 2022, between the hours of 9:57 a.m., and 11:15 a.m., survey staff toured the home with Maintenance Director (MD)-D. At approximately 11:05 a.m., survey staff observed and verified a window in resident room #5 opened into resident room #4. MD-D verbally confirmed survey staff observations during the facility tour. Licensed Assisted Living Director (LALD)-A stated the resident in bedroom #5 has been moved to a different room until another form of egress is provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470		

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WOODCREST ASSISTED LIVING	1201 RIDGEVIEW TERRACE NE ALEXANDRIA, MN 56308

(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
01470	Continued From page 25 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470		

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01470	Continued From page 26 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to 144G licensing requirements for two of two employees (unlicensed personnel (ULP)-C and clinical nurse supervisor (CNS)-B) with employee records reviewed. This had potential to affect all seven 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, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 6, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they understood assisted living licensure regulation and requirements. Additionally, CNS-B stated, "some of it I may know. I know she [LALD] would know all of it." CNS-B CNS-B was hired on October 26, 2021, to provide direct care to residents and to supervise unlicensed personnel.	01470		

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01470	Continued From page 27 Document titled 90-Day/Annual Nursing Assessment dated and signed by CNS-B on March 22, 2022, indicated CNS-B had provided assessment services for R2. CNS-B's employee record lacked documentation of the following required orientation: - an overview of this chapter (144G); - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. ULP-C On June 7, 2022, at 2:07 p.m., the surveyor observed ULP-C provide medication administration to R1. ULP- C was hired on December 18, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-C's employee record lacked documentation of the following required orientation: - an overview of this chapter (144G); - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; and - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On June 7, 2022, at approximately 3:55 p.m., LALD-A confirmed CNS-B and ULP-C did not	01470		

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01470	Continued From page 28 receive the required assisted living licensure orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure	01690		

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01690	Continued From page 29 security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN). 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: During the entrance conference on June 6, 2022, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services to the licensee's residents. The licensee lacked the following required policies: - preparing and giving medications; - verifying that prescription drugs are administered as prescribed; - documenting medication management activities; - controlling and storing medications; and - resolving medication errors.	01690		

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01690	Continued From page 30 On June 7, 2022, at approximately 1:40 p.m., LALD-A confirmed the licensee lacked the above noted policies. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01690		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	01730		

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01730	Continued From page 31	01730		

management services; and
(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

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 medication management record for each resident to include all required content for two of two 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

During the entrance conference on June 6, 2022, at approximately 11:00 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee

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01730	Continued From page 32	01730		

provided medication management services to the licensee's residents.

R1
R1's diagnoses included type II diabetes with nephropathy, atherosclerotic heart disease and morbid obesity.

R1's service plan dated September 7, 2021, indicated R1 received services including medication administration.

R1's medication administration record (MAR) dated May 2022, included the following medications: one blood thinner, two nerve anti-inflammatories, two antianxiety, one antibiotic, one nebulizer, one cholesterol reducer, one antibronchospasm, two insulins, one stomach acid reducer, one blood pressure reducer, two inhalers, two eyedrops, two diuretics, one narcotic pain medication, one pain patch, one stool softener, two congestion reducers, three topical ointments and three vitamin supplements.

On June 7, 2022, at approximately 2:07 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's afternoon medications.

R2
R2's diagnoses included vitamin D deficiency, amnesia, malignant tumor of the prostate and conduction disorder of the heart.

R2's service plan dated December 27, 2021, indicated R2 received services including medication administration.

R2's MAR dated May 2022, included the following medications: one blood thinner, one blood

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01730	Continued From page 33 pressure reducer, two memory enhancers, one antianxiety, one cholesterol reducer, one narcotic pain medication and three vitamin supplements. R1 and R2's individualized medication management plan lacked the following: - documentation of specific resident instructions relating to the administration of medications; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On June 8, 2022, at approximately 10:50 a.m., CNS-B confirmed R1 and R2's individualized medication management plans did not include all the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=E	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.	01770		

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01770	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to ensure documentation of medication setup was completed at the time of setup and included all the required content for two of two 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 6, 2022, at approximately 11:10 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services to include medication setup. CNS-B stated she set up medications for all residents into medication caddies (a medication storage container that is divided into compartments organized by the days of the week and times of the day). R1 R1's diagnoses included type II diabetes with nephropathy, atherosclerotic heart disease and morbid obesity. R1's service plan dated September 20, 2021, indicated R1 received services including	01770		

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01770	Continued From page 35 medication administration. R1's prescriber orders dated May 26, 2022, included: - aspirin 81 milligram (mg) daily; - buspirone HCL 5 mg twice daily; - carbidopa/levodopa 25-100 mg three times daily; - Crestor 40 mg daily; - Cymbalta 60 mg daily; - Daliresp 500 microgram (mcg) daily; - Combivent nebulizer twice daily; - gabapentin 300 mg three times daily; - isosorbide mononitrate extended release (ER) 60 mg daily; - Lantus 100 unit/milliliter (mL) 35 units at bedtime; - Klor-Con 10 milliequivalents (MEQ) three times daily; - magnesium oxide 400 mg daily; - Novolog 100 units/mL sliding scale; - omeprazole 40 mg daily; - propranolol HCL 10 mg twice daily; - Restasis 0.05% one drop to both eyes twice daily; - Singulair 10 mg daily; - TheraTears 0.25% one drop both eyes twice daily; - torsemide 20 mg three tabs daily; - trazadone 50 mg daily; - Trelegy Ellipta 100-62.5-25 microgram (mcg) inhaler daily; - vitamin D3 2000 units daily; and - Zetia 10 mg daily. R2 R2's diagnoses included vitamin D deficiency, amnesia, malignant tumor of the prostate and conduction disorder of the heart.	01770		

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01770	Continued From page 36 R2's service plan dated December 27, 2021, indicated R2 received services including medication administration. R2's prescriber orders dated March 25, 2022, included: - aspirin 81 mg daily; - calcium 600 mg daily; - donepezil 10 mg daily; - ginkoba 40 mg three tabs daily; - losartan 50 mg daily; - memantine HCL 10 mg twice daily; - Seroquel 12.5 mg twice daily; - simvastatin 20 mg daily; - trazadone HCL 50 mg daily; and - vitamin D3 2000 units two tabs daily. On June 6, 2022, at 2:33 p.m., CNS-B provided documentation titled Charting Notes for R1 and R2. The documents contained a one sentence statement written by CNS-B on June 2, 2022, "medication filled x1 week." R1 and R2's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain	01930		

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01930	Continued From page 37 up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 6, 2022,	01930		

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01930	Continued From page 38 at approximately 11:00 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents as prescribed. On June 6, 2022, at approximately 11:15 a.m., the licensee's assisted living licensing policies and procedures were requested from LALD-A. The policies and procedures provided did not include treatment and therapy policies to address the following: - providing the treatment or therapy; - documenting treatment or therapy activities; - educating and communicating with residents about treatments or therapies they are receiving; - monitoring and evaluating the treatment or therapy; and - communicating with the prescriber. On June 8, 2022, at approximately 10:40 a.m., LALD-A confirmed the above noted treatment and therapy management services policies and procedures had not been developed. Additionally, LALD-A stated, "we are waiting on the big blue book of policies." LALD-A stated the policy book had been purchased through a provider organization, however, had not been received by licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01930		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of	01940		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01940	Continued From page 39 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 observation, interview and record review, the licensee failed to develop an individual treatment management plan to include all required content for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30701	A. BUILDING: _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST ASSISTED LIVING	1201 RIDGEVIEW TERRACE NE ALEXANDRIA, MN 56308

(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
01940	Continued From page 40	01940		

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

During the entrance conference on June 6, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents.

R1
R1's diagnoses included type II diabetes with nephropathy, atherosclerotic heart disease and morbid obesity.

R1's service plan dated September 7, 2021, indicated R1 received services to include oxygen therapy continuous via nasal cannula 3- 4 liters per minute (LPM) and glucose (sugar) tests daily.

On April 7, 2022, at approximately 12:05 p.m., the surveyor observed unlicensed personnel (ULP)-C conduct a glucose (sugar) test for R1 with results of 70 milligrams per deciliter (mg/dl). At approximately 12:09 p.m., ULP-C verified R1's oxygen concentrator was set at 4 liters per minute (LPM).

R1's record lacked an Individualized Treatment and Therapy plan to include the following:
- a statement of the type of services that will be provided;
- documentation of specific resident instructions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30701	A. BUILDING: _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST ASSISTED LIVING	1201 RIDGEVIEW TERRACE NE ALEXANDRIA, MN 56308

(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
01940	Continued From page 41 relating to the treatment or therapy administration; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On June 8, 2022, at approximately 10:45 a.m., CNS-B confirmed R1's Individualized Treatment and Therapy Plans lacked the above noted requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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.	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30701	A. BUILDING: _____ B. WING _____	06/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST ASSISTED LIVING	1201 RIDGEVIEW TERRACE NE ALEXANDRIA, MN 56308

(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	Continued From page 42 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: A review of the Hazard Vulnerability Assessment showed global issues such as fire, gas leaks, and epidemics had been identified. Local hazards that are site, building, and population-specific had not been developed. During an interview on June 07, 2022, at 11:40 a.m., the Licensed Assisted Living Director (LALD)-A stated she had completed the hazard vulnerability assessment on and around the facility property, but the provided documentation did not address site specific hazards such as the two fireplaces and elopement preventative issues. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30701	A. BUILDING: _____ B. WING _____	06/08/2022

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WOODCREST ASSISTED LIVING	1201 RIDGEVIEW TERRACE NE ALEXANDRIA, MN 56308

(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
02110	Continued From page 43	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (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.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WOODCREST ASSISTED LIVING	1201 RIDGEVIEW TERRACE NE ALEXANDRIA, MN 56308

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02110	Continued From page 44 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed and/or implemented. 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). The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 10 residents. On June 8, 2022, at approximately 10:45 a.m., licensed assisted living director (LALD)-A confirmed the inclusive list of dementia care policies and procedures had not been developed, implemented or provided to each resident and/or representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02310 SS=F	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 45 living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen. This had the potential to affect all seven residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 6, 2022, at approximately 11:35 a.m., the surveyor observed four unsecured oxygen cylinders in R1's closet. One was lying down and three were standing scattered throughout the closet. R1 stated "that is where they [oxygen bottles] have always been." On June 6, 2022, at 12:16 p.m., clinical nurse supervisor (CNS)-B confirmed she was aware R1's oxygen was in the closet unsecured and stated, "her daughter had taken the holder with them to Fargo and hasn't brought it back yet." The Minnesota Department of Health (MDH) utilizes guidance from the National Fire Protection	02310		

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02310	Continued From page 46 Association, Standard 99 (NFPA 99), Health Care Facilities Code and directs that all oxygen cylinders must be secured with chains or racks to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03000	Continued From page 47 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with the requirement of immediately reporting suspected maltreatment of a vulnerable adult to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R2) reviewed. R2 left the facility and was returned by law enforcement. The licensee was aware of the incident but did not file a MAARC report. 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	03000		

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03000	Continued From page 48	03000		

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:

The licensee held an assisted living with dementia facility license and was licensed for a bed capacity of ten (10) residents. The current census at the facility was seven residents.

On June 6, 2022, at approximately 10:57 a.m., during the entrance conference, licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated there had been one incident of elopement at the facility with R2 on February 25, 2022.

R2
R2's diagnoses included dementia, vitamin D deficiency and amnesia.

R2's assessment dated March 22, 2022, indicated R2 was at risk for elopement with a history of elopement from prior facility.

R2's Assisted Living Vulnerability/Risk Assessment and Abuse Prevention Plan (IAPP) dated December 27, 2021, indicated R2 was vulnerable in the area of grooming, hygiene, dressing, medications, needed assistance with the use of a phone, was unable to and unaware of ability to exercise judgement regarding or consent to sexual activity, inability to identify potentially dangerous situations, inability to deal with verbally or aggressive persons, lack of communication skills, inappropriate social behaviors, unaware of inclement weather hazards, does not recognize or protect self from potential safety risks, does not recognize or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03000	Continued From page 49	03000		

protect self against potentially abusive/harmful situations and does not respond to emergency situations or warning devices and impaired judgement/actions when agitated, anxious or upset.

R2's service plan dated December 27, 2021, indicated R2 received assistance with appointments, transportation, money management, socialization, dressing, grooming, bathing, meal setup, medication management, redirection and reorientation.

R2's progress notes dated February 25, 2022, indicated R2 had walked away from the facility at approximately 9:09 a.m., and had been picked up and returned to the facility at approximately 9:50 a.m., by law enforcement.

R2's incident report dated February 25, 2022, stated R2 was seen on camera (post incident) leaving the facility at approximately 9:09 a.m., and was found by law enforcement at a four-way intersection and was returned to the facility 9:50 a.m. The determination on the incident report indicated the door alarm was inactive at the time of the incident and staff had failed to perform hourly safety checks on the alarms. The registered nurse (RN) on call was notified as well as R2's family at the time of incident.

During interview on June 7, 2022, at approximately 10:52 a.m., LALD-A stated she did not believe a MAARC report was indicated as LALD-A stated she was told by MAARC "that it was up to us if we wanted to file a report or not. There was no harm to the resident and he eloped all the time from his last facility." LALD-A was unable to provide documentation that a phone call had been made to MAARC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03000	Continued From page 50 The licensee's Interventions For Residents at Risk of Wandering and/or Elopement policy dated January 1, 2019, indicated the RN would report the incident to the Common Entry Point immediately (within 24 hours) reassess the resident and determine if changes were needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health

PO Box 64495
St Paul, Minnesota
651-201-4500

Type: Full
Date: *06/06/22*
Time: 11:00:00
Report: 1008221028

Food and Beverage Establishment Inspection Report

Location:
Woodcrest Assisted Living
Woodcrest Assited Living
1201 Ridgeview Terrace NE
Alexandria, MN56308
Douglas County, 21

Establishment Info:
ID #: 0037892
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207662451
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.

4-200 Equipment Design and Construction

4-204.115 ** Priority 2 **

MN Rule 4626.0635 Provide a temperature measuring device in the warewashing machine that indicates the temperature of the water in the wash tank, rinse tank, and the water that enters the sanitizing final rinse manifold or the chemical sanitizing solution tank.

PROVIDE A TEMPERATURE MEASURING DEVICE IN THE UNDERCOUNTER DISH MACHINE.

Comply By: 06/08/22

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THE KITCHEN HAS DOMESTIC EQUIPMENT, CABINETRY AND FINISHES AND SHALL DISCONTINUE SERVING TCS (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) FOODS THAT ARE HELD FOR MORE THAN SAME-DAY SERVICE. CONTINUED IN GENERAL COMMENT.

Comply By: 06/20/22

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

REPAIR THE SINK IN THE KITCHEN. THE RIGHT SIDE OF THE SINK WAS BACKING UP DURING THE INSPECTION.

Type: Full
Date: *06/06/22*
Time: 11:00:00
Report: 1008221028
Woodcrest Assisted Living

Food and Beverage Establishment Inspection Report

Comply By: 06/07/22

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: LEFT OVER BEEF STROGANOFF - KITCHEN REFRIGERATOR
Violation Issued: No

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

CONTINUED FROM MN RULES.4626.0506G - FOOD THAT IS TCS SHALL BE PREPARED FOR SAME DAY SERVICE ONLY. NO TCS FOOD SHALL BE STORED IN THE REFRIGERATOR FOR MORE THAN 24 HOURS.

THINGS TO REMEMBER:

1 THE CERTIFIED FOOD PROTECTION MANAGER SHOULD BE ROUTINELY CONDUCTING SELF INSPECTIONS TO ENSURE THAT EMPLOYEES ARE FOLLOWING PROPER FOOD HANDLING PRACTICE.

2 EDUCATE EMPLOYEES ON THE IMPORTANCE OF REPORTING TO MANAGEMENT ANY ILLNESS THEY HAVE OR HAVE HAD RECENTLY. MANAGEMENT SHOULD EXCLUDE ANY WORKERS ILL WITH VOMITING OR DIARRHEA FROM HANDLING FOOD, AND THEY SHOULD KEEP AN UP TO DATE EMPLOYEE ILLNESS LOG.

3 THERE SHOULD BE A PERSON IN CHARGE A THE ESTABLISHMENT DURING ALL HOURS OF OPERATION. THIS PERSON SHOULD ENSURE THAT EMPLOYEES ARE PRACTICING GOOD HAND WASHING PROCEDURES, INCLUDING BEING KNOWLEDGEABLE ABOUT WHEN HAND WASHING SHOULD BE DONE AND HOW TO PROPERLY WASH HANDS.

4. EMPLOYEES SHOULD USE SPATULA, TONGS, DELI TISSUE, GLOVES OR SOME OTHER APPROVED MEANS TO PREVENT ANY DIRECT BARE HAND CONTACT WITH READY TO EAT FOODS.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1008221028 of 06/06/22.

Certified Food Protection Manager: Kayla J Thoennes

Certification Number: 66400 Expires: 02/27/25

Signed: Report emailed
Establishment Representative

Signed: Inspector ID# 1088

Public Health Sanitarian 3
Fergus Falls District Office
651-201-4500
health.foodlodging@state.mn.us

Report #: 1008221028

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
PO Box 64495
St Paul, Minnesota

No. of RF/PHI Categories Out	0	**Date**	06/06/22
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:00:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	City/State	Zip Code	Telephone
Woodcrest Assisted Living	Woodcrest Assited Living	Alexandria, MN	56308	3207662451

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037892		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygenic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
Proper cooking time & temperature			
19	IN OUT N/A N/O		
Proper reheating procedures for hot holding			
20	IN OUT N/A N/O		
Proper cooling time & temperature			
21	IN OUT N/A N/O		
Proper hot holding temperatures			
22	IN OUT N/A		
Proper cold holding temperatures			
23	IN OUT N/A N/O		
Proper date marking & disposition			
24	IN OUT N/A N/O		
Time as a public health control: procedures & records			
Consumer Advisory			
25	IN OUT N/A		
Consumer advisory provided for raw/undercooked food			
Highly Susceptible Populations			
26	IN OUT N/A		
Pasteurized foods used; prohibited foods not offered			
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
Food additives: approved & properly used			
28	IN OUT		
Toxic substances properly identified, stored, & used			
Conformance with Approved Procedures			
29	IN OUT N/A		
Compliance with variance/specialized process/HACCP			

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A		
Pasteurized eggs used where required				
31				
Water & ice obtained from an approved source				
32		IN OUT N/A		
Variance obtained for specialized processing methods				
Food Temperature Control				
33				
Proper cooling methods used; adequate equipment for temperature control				
34		IN OUT N/A N/O		
Plant food properly cooked for hot holding				
35		IN OUT N/A N/O		
Approved thawing methods used				
36				
Thermometers provided & accurate				
Food Identification				
37				
Food properly labled; original container				
Prevention of Food Contamination				
38				
Insects, rodents, & animals not present				
39				
Contamination prevented during food prep, storage & display				
40				
Personal cleanliness				
41				
Wiping cloths: properly used & stored				
42				
Washing fruits & vegetables				

			COS	R
Proper Use of Utensils				
43				
In-use utensils: properly stored				
44				
Utensils, equipment & linens: properly stored, dried, & handled				
45				
Single-use/single service articles: properly stored & used				
46				
Gloves used properly				
Utensil Equipment and Vending				
47	X			
Food & non-food contact surfaces cleanable, properly designed, constructed, & used				
48	X			
Warewashing facilities: installed, maintained, & used; test strips				
49				
Non-food contact surfaces clean				
Physical Facilities				
50				
Hot & cold water available; adequate pressure				
51	X			
Plumbing installed; proper backflow devices				
52				
Sewage & waste water properly disposed				
53				
Toilet facilities: properly constructed, supplied, & cleaned				
54				
Garbage & refuse properly disposed; facilities maintained				
55				
Physical facilities installed, maintained, & clean				
56				
Adequate ventilation & lighting; designated areas used				
57				
Compliance with MCIAA				
58				
Compliance with licensing & plan review				

Food Recalls:

Person in Charge (Signature) Report emailed **Date:** 06/06/22

Inspector (Signature) Inspector ID# 10058