Electronically Delivered

June 17, 2024

Licensee
Green Lakes Homes
11540 Norway Street Northwest
Minneapolis, MN 55448

RE: Project Number(s) SL39808015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 31, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/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 correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

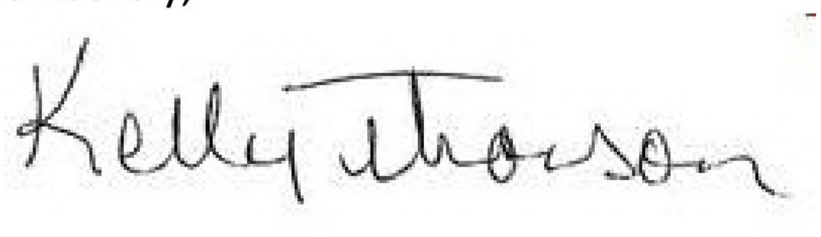
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39808	A. BUILDING: _____ B. WING _____	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LAKES HOMES	11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39808015 On May 28, 2024, through May 30, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 5 residents receiving services under the Provisional Assisted Living 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 Home Care 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 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 28, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	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	0 630		

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0 630	Continued From page 2 vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately identify all areas of vulnerability on the individual abuse prevention plan (IAPP) for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on November 27, 2023, with diagnoses to include major depressive disorder. R1's signed service plan dated November 27, 2023, indicated R1 received serviced including assistance with housekeeping, laundry, meals, activities of daily living due, ambulation, bathing reminders, and medication administration. On May 28, 2024, at 12:27 p.m., supervisor (S)-B	0 630		

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0 630	Continued From page 3 was observed to assist R1 with afternoon medication administration. R1's medical record included an IAPP dated January 29, 2024, R1's IAPP lacked an accurate assessment of: - assessment of the resident's risk of abusing other vulnerable adults or minors; and -statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults or minors and risk of self-abuse. On May 30, 2024, at 11:40 a.m., clinical nurse supervisor (CNS)-C stated, they were unaware and unable to view the required areas of R1's vulnerability on R1's IAPP. 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 4 (5) have a written policy and procedure regarding missing 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 interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to 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 potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - program patient population; - quarterly review of missing resident policy; -policies and procedures for medical documentation;	0 680		

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0 680	Continued From page 5 -roles under a waiver declared by secretary; and -emergency prep training and testing. On May 28, 2024, at 2:00 p.m., surveyor and agent (A)-A reviewed the EPP together. A-A stated the EPP was created and overseen by A-A, and stated they were unaware of the requirements that were missing upon review. The licensee's Emergency Preparedness policy dated January, 1, 2022, indicated the licensee had identified a plan in place to assure the safety and the wellbeing of the residents and staff during periods of an emergency disasters. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 6 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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 potential to affect a large portion or all of the residents). The findings include: On May 29, 2024, the clinical nurse supervisor (CNS)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and	0 810		

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0 810	Continued From page 7 evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "7.05 Fire", dated 02/16/2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on May 29, 2024, at 2:30	0 810		

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0 810	Continued From page 8 p.m., CNS-C stated they had not had an opportunity to update the policy to make it site specific. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. CNS-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 970		

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0 970	Continued From page 9 or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on May 28, 2024, at 11:00 a.m., the surveyor asked for a copy of the licensee's assisted living contract. The assisted living contract was provided and later reviewed by the surveyor. The licensee's Assisted Living Contract included a clause Indemnification: Licensee shall not be liable for any damage or injury to the resident, or any other person, or to property, occurring in the premises. Clause Liability: The resident agreed to be liable and responsible for all obligations herein reference, monetary and otherwise, of the resident and where this contract has been executed. On April 23, 2024, at 11:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided the same assisted living contract to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060		

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01060	Continued From page 10 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	01060		

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01060	Continued From page 11 licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R1) who was hospitalized. 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 problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and R1's diagnoses included major depressive disorder. R1's signed service plan dated November 27, 2023, indicated R1 received serviced including assistance with housekeeping, laundry, meals, activities of daily living due, ambulation, bathing reminders, and medication administration. R1's Incident Report dated April 30, 2024, at 3:00 p.m. indicated R1's breathing was shallow and heart rate increased with the paramedics called and R1 brough to the emergency room with a diagnosis of an infection. R1's Progress Note dated May 3, 2024, at 10:59	01060		

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	39808	A. BUILDING: _____ B. WING _____	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LAKES HOMES	11540 NORWAY STREET NORTHWEST MINNEAPOLIS, MN 55448

(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
01060	Continued From page 12 a.m. indicated R1 returned to the licensee. On May 30, 2024, at 11:41 a.m., clinical nurse supervisor (CNS)- C stated they were not aware of the above requirement and the licensee was not currently providing a notice when residents were hospitalized. In addition, CNS-C stated they were not aware the Office of Ombudsman for Long-Term Care needed to be notified if the resident was relocated and had not returned to the facility within four days. The licensee's Discharge and Transfer of Residents policy dated, August 1, 2021, indicated in the event of an emergency relocation, the facility would as soon as possible provide a written notice of emergency relocation to the resident, the resident legal representative, the residents designated representative, and the Office of Ombudsman for Long-Term Care within four (4) days if the resident had not returned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under	01290		

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01290	Continued From page 13 section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one employee, supervisor (S)-B. 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: S-B was hired on May 16, 2022, to provide direct care services to residents. On May 28, 2024, at 12:27 p.m., S-B was observed to assist R1 with afternoon medication administration. S-B's employee record contained a background study clearance dated May 17, 2022, affiliated to licensee's head office, HFID 37977. On May 29, 2024, at 1:07 p.m., clinical nurse supervisor (CNS)-C stated "We were able to get in touch with NetStudy and were informed to	01290		

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01290	Continued From page 14 process a new affiliation from the previously completed Background study. Unfortunately, the system does not allow us to select an older date/time that aligns with the actual start date at the Norway Facility." The licensee's undated background screening policy indicated the licensee required a background screening to have been completed on all final candidates for employment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and	01500		

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01500	Continued From page 15 reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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 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 annual training for each 12 months of	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39808	A. BUILDING: _____ B. WING _____	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01500	Continued From page 16 employment in the required topics for one of one employee (supervisor (S)-B). 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: S-B was hired on May 16, 2022, to provide direct care services to residents. On May 28, 2024, at 12:27 p.m., S-B was observed to assist R1 with afternoon medication administration. S-B's employee record lacked evidence S-B had successfully completed annual training in the following areas: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -infection control techniques; -effective approaches to use problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and -dementia training: met two (2) hours annually. On May 30, 2024, at 12:23 p.m., clinical nurse supervisor (CNS)-C stated they have oversight with assigning education via educare (a computer system for education) to all staff members.	01500		

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01500	Continued From page 17 CNS-C stated unsure how the education was missed. The licensee's Annual Training Requirements policy undated, indicated all staff that provide direct services must complete at least eight (8) hours of annual training for each 12 months of employments that included to have reviewed the assisted living bill of rights and infection control. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for three of four residents (R1, R2, R4). In addition, the licensee failed to ensure medications were maintained bearing legible information labeled on medication for three of four residents (R1, R2, R3). 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	01890		

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01890	Continued From page 18 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: On May 28, 2024, at 12:32 p.m., the surveyor and supervisor (S)-B observed licensee's locked medication cabinet which contained the licensee's resident's medications and observed the following expired medications and lack of a medication label: Expired Medications R1 -mylanta with an expiration date of April 2024; -tylenol with an expiration date of May 27, 2022; -meloxicam with an expiration date of April 30, 2024; -lamotrigine with an expiration date of January 26, 2024; and -carvedilol with an expiration date of April 24, 2024. R2 -refresh eye drops with an expiration date of January 2024. R4 -atorvastatin with an expiration date of March 26, 2024; -finasteride with an expiration date of March 26, 2024; and -senna with an expiration date of March 36, 2024. Medications Bearing Legible Information R1	01890		

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01890	Continued From page 19 -unknown medications in a medication bottle with no label -mylanta R2 -refresh eye drops -dorsolam eye drops R3 -fluticasone On May 28, 2024, at 12:51 p.m., S-B stated S-B had oversight of monthly medication cabinet checks and unsure how the medications were missed. S-B stated that expired medications are disposed of with a medication destroyer or brought the local police station after notification to the registered nurse. The licensee's Storage and Control of Medications policy dated August 1, 2021, indicated that medications are labeled completely and legible and should contain the prescription number and mane of medication; strength and quality; expiration date for time-dated medications; directions for use; residents name' prescribers name; date issued; and mane and address of the pharmacy. The nurse checks the medications expiration dates and notes the medications needing to be reordered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *05/28/24*
Time: 15:39:08
Report: 8058241135

Food and Beverage Establishment Inspection Report

Location:
Greenlakes LLC
11316 Palm Street NW
Coon Rapids, MN55433
Anoka County, 02

Establishment Info:
ID #: 0040792
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
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.

2-100 Supervision

2-102.12AMN

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

FOOD SAFETY TRAINING CERTIFICATE NEEDS TO BE TRANSFERRED TO CFPM -APPLICATION PROVIDED

Comply By: 07/31/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

REPAIR CABINET DOOR ABOVE MICROWAVE

Comply By: 06/30/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: GROUND BEEF
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: PEPPERONI
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Type: Full
Date: *05/28/24*
Time: 15:39:08
Report: 8058241135
Greenlakes LLC

Food and Beverage Establishment Inspection Report

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR JESSICA DETERS
ESTABLISHMENT REP FOLARIN ADEDESI

RESIDENTIAL HOME WITH NON COMMERCIAL KITCHEN, NOT COMMERCIAL APPLIANCES AND FINISHES

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 8058241135 of 05/28/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us