Electronically Delivered

July 24, 2025

Licensee
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014

RE: Project Number(s) SL30745017

Dear Licensee:

On July 8, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 16, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

May 13, 2025

Licensee
Lino Lakes Assisted Living
725 Town Center Parkway
Lino Lakes, MN 55014

RE: Project Number(s) SL30745017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 16, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

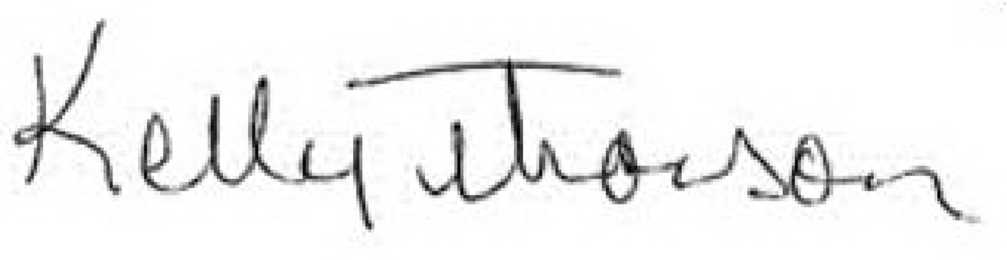
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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 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: SL30745017 On April 14, 2025, through April 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 64 residents; 64 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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0 480	Continued From page 1 must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean	0 480		

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0 480	Continued From page 2 and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 14, 2025, 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		

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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 (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 have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and 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	0 680		

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0 680	Continued From page 4 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 the residents). The findings include: The licensee's EPP dated June 10, 2024, lacked documentation including all the required elements of: -documentation of annual review and update - missing resident quarterly review On April 16, 2025, at 11:25 a.m., licensed assisted living director (LALD)-A stated they need to update the EPP with the new management contact information. LALD-A further stated they complete missing person drills, but the policy is not reviewed quarterly. The licensee's Emergency Preparedness Program Policies and Procedures Overview policy dated June 10, 2024, indicated the plan will be maintained in accordance to state and federal guidelines will be reviewed and updated annually. The licensee's Missing Resident policy dated February 5, 2024, indicated [the management company] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 775	Continued From page 5	0 775		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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 of the residents). Findings include: On a facility tour on April 14, 2025, from 12:45 p.m. to 4:15 p.m., with licensed assisted living director (LALD)-A, director of maintenance (DM)-D, and regional maintenance (RM)-E, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR SPECIAL LOCKING ARRANGEMENTS There was a controlled egress locking system installed on all exit doors leading out of the dementia care unit to the exterior exit path.	0 775		

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0 775	Continued From page 6 The controlled egress door locking system was not provided with a device capable of deactivating the controlled egress door system hardware to the unlocked position from the nurse station or other approved location within the locked unit. It was explained the controlled egress locking system is required to be provided with a device capable of deactivating the controlled egress door hardware to the unlocked position from the nurse station or other approved location within the locked unit in order for occupants to exit in the event of a fire or similar emergency. During an interview at on April 14, 2025, at 12:30 p.m., LALD-A, DM-D, and RM-E, stated the procedures required to operate and unlock the delayed egress door locking system were not included in the fire safety and evacuation plan. It was explained that the procedures required to operate and unlock the delayed egress locking system in order for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. USED SMOKING MATERIAL DISPOSAL There was a plastic water bottle containing used cigarette butts and used cigarette butts were discarded on the ground outside around the exterior door next to resident sleeping room 134. There were used cigarette butts disposed on the ground around the wood constructed roof structure designated as the smoking area. There	0 775		

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0 775	Continued From page 7 was an appropriate cigarette disposal dispenser located in the designated smoking area. It was explained that used cigarette smoking materials are required to be disposed of in appropriate metallic containers or containers designed and manufactured for the use of dispensing used cigarette materials. CARBON MONOXIDE ALARMS/ DETECTION There was single station carbon monoxide alarms installed in the corridors of the three-story assisted living portion of the facility that were not tied into the building fire alarm system for notification. The carbon monoxide alarms sounded locally at the location of the activated alarm only. There was not carbon monoxide alarms installed within ten feet of all sleeping rooms in the three-story assisted living portion of the facility. When carbon monoxide detectors are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all resident sleeping rooms. There was carbon monoxide detectors installed near the sources of carbon monoxide and tied into the fire alarms system for notification of occupants in the dementia care secured unit. Carbon monoxide alarms and detections systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. SMOKE ALARM MAINTENANCE	0 775		

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0 775	Continued From page 8 During the tour DM-D, removed the smoke alarms in order to observe the manufacture date. The manufacture date on the smoke alarm in resident sleeping room 228 was 2005 and resident room 27 was 2013. The smoke alarm in resident sleeping unit 102 did not operate when tested and the manufacture date stamped on the alarm was 2006. All smoke alarms are required to be replaced within ten years of manufacture date and maintained in working condition in accordance with MSFC and the alarm manufactures installation instructions. FIRE RESISTANT RATED DOOR MAINTENANCE During the tour fire resistant rated doors throughout the facility were tested for operation to verify the doors automatically close and latch as designed and installed at the time of construction approval. The fire-resistant rated doors in the trash room on third floor did not positively latch in the closed position automatically. The door latching hardware on the fire-resistant rated doors of resident sleeping unit 306 and 308 was missing and the doors did not positively latch in the closed position automatically. The existing door latch and lock hardware on resident sleeping unit 234 was replaced requiring alteration to the existing door. It was explained that existing fire-resistant rated doors are required to be maintained as installed at the time of construction approval and not altered.	0 775		

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0 775	Continued From page 9 The door leading into resident sleeping unit 232 was not latched and would not automatically close and latch upon testing for operation during the tour. The fire-resistant rated door leading into the library was missing latch hardware and did not automatically close and latch. The first-floor laundry room door in the three-story portion of the assisted living facility did not automatically close and latch. The storage room door did not automatically close and latch in the exit stairway on first floor of the three-story portion of the facility near resident room 133. The door did not automatically close and latch leading out of the commercial kitchen into the corridor and marked with an exit sign. The door did not automatically close and latch leading into the trash room on second floor. The closer arm was removed from the door closer leading into the activities office of the secured dementia care unit. The door strike for the latch was missing and the door did not positively latch on the third-floor stairway enclosure door. It was explained that all fire-resistant rated doors are required to automatically close, and latch as designed and installed at the time of construction approval. MARKED EXIT PATH OBSTRUCTION	0 775		

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0 775	Continued From page 10 The door latch hardware was installed on the exterior (non-egress) side of the exterior exit gate leading to the public way from the marked exterior exit door leading onto the dementia care patio. It was explained that gates or doors in exit paths from marked exterior exit doors are required to be provided with hardware that is operable from the egress side in the direction of egress travel of the door or gate. There was not a handle provided to pull the door open in order to exit from inside the med office on second floor. It was explained that exit access doors are required to be provided with hardware to allow the door to be opened from the egress side in the direction of egress travel. ELECTRICAL MULTI PLUG ADAPTERS There was an electrical multi plug adapter not protected from overcurrent with two refrigerators plugged into it, in the nurse office on second floor. It was explained that major appliances such as refrigerators are required to be plugged directly into a wall outlet or one per overcurrent protected power strip. COMMERCIAL KITCHEN HOOD AND DUCT MAINTENANCE It was observed the cleaning tag for the commercial kitchen hood and duct cleaning indicated the last cleaning/ inspection was completed May 2, 2024. It was explained commercial kitchen hood and duct systems are required to be cleaned or inspected semi-annually in accordance with	0 775		

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0 775	Continued From page 11 MSFC in Minnesota Rules Chapter 7511. EMERGENCY EGRESS LIGHTING MAINTENANCE During the tour the emergency light across the hall from resident sleeping unit 204 was tested and did not operate as designed. It was explained that all emergency lighting and lighted exit signs are required to be provided with backup power to light the path of egress and exit signs in the event of a power outage. During the facility tour LALD-A, DM-D, and RM-E, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair	0 800		

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0 800	Continued From page 12 and operation regarding the health, safety, and well-being of the residents. 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, 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: On a facility tour on April 14, 2025, from 12:45 p.m. to 4:15 p.m., with licensed assisted living director (LALD)-A, director of maintenance (DM)-D, and regional maintenance (RM)-E, the surveyor made the following observations of facility disrepair: There was damage to the drywall wall covering caused by moisture in the furnace closet in resident sleeping unit 204. All wall cavities are required to be maintained free of water infiltration that causes moisture damage to the structure. Two handrail ends that return to the wall were missing creating a sharp end, one in the corridor across from resident sleeping unit 36 and one in the corridor near the main building entrance/ reception area. There was door trim missing exposing sharp objects on resident sleeping unit entry door 307, on the door leading into the break room and the door leading into the trash room on second floor.	0 800		

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0 800	Continued From page 13 During the facility tour LALD-A, DM-D, and RM-E, verified the above listed observations while accompanying on the tour. 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) staff 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) Staff 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 staff 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	0 810		

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0 810	Continued From page 14 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 required content, make the plan readily available, provide required training and drills. 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 April 14, 2025, at 11:50 a.m., licensed assisted living director (LALD)-A, director of maintenance (DM)-D, and regional maintenance (RM)-E, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP, failed to include the following: The available FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or	0 810		

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0 810	Continued From page 15 similar emergency relative to the facility's building layout and environmental risks. The plan inappropriately included general fire safety procedures based on the R.A.C.E. acronym only, and did not include specific procedures based on the features and elements of this building and on this site. The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available FSEP included standard resident evacuation procedures, but failed to provide specific individualized unique needs of residents evacuation. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. It was explained the individual resident unique needs for evacuation are required to be readily available to all staff, at all times within the facility, for use in responding to a fire or similar emergency. This list of unique resident needs for evacuation is also a tool used by emergency responders to gain knowledge of residents needs. During an interview on April 14, 2025, at 12:00 p.m., RM-E, and LALD-A, stated they are working on fully updating the FSEP but the detailed employee procedures, resident procedures, and unique needs for individual residents evacuation in the event of a fire or similar emergency were not available. TRAINING	0 810		

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0 810	Continued From page 16 Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation the required training was completed. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the residents were provided the training annually. During an interview on April 14, 2025, at 12:10 p.m., RM-E, DM-D, and LALD-A, stated documentation was not available indicating training was completed by employees and provided to residents as required. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation drills were completed twice during the night shift and during the months of November 2024 and January 2025. During an interview on April 14, 2025, at 12:00 p.m., RM-E, DM-D, and LALD-A, stated the documentation of evacuation drills provided was the only documentation available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01370	Continued From page 17	01370		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 18 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and, record review, the licensee failed to ensure required training was completed for one of two employees (unlicensed personnel (ULP)-F). 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: ULP-F began employment on November 25, 2024, to provide direct care services to residents. On April 15, 2025, at 9:45 a.m., the surveyor observed ULP-F change out a portable oxygen tank for R2. ULP-F's employee record lacked documentation of the following required training and competencies to be completed by ULP: -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the assisted living provider Appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic	01370		

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01370	Continued From page 19 devices, care and use of hearing aids, dressing and assisting with toileting -standby assistance techniques and how to perform them -medication, exercise, and treatment reminders -preparation of modified diets as ordered by a licensed health professional -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -procedures to utilize in handling various emergency situations -awareness of commonly used health technology equipment and assistive devices. On April 15, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A stated they were sure ULP-F completed all his training, there just isn't documentation of it in his record. They have been through many nurse and leadership changes and some documents are just missing. On April 15, 2025, at 3:08 p.m., ULP-F stated he did have all his required training, both on the computer and with the registered nurse. ULP-F further stated he had to demonstrate competency to the nurse for the training including medication administration, oxygen management, and blood glucose monitoring. The licensee's Assisted Living Orientation- ULP Staff policy dated June 19, 2023, indicated newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations which includes the above missed training. No further information provided.	01370		

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01370	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure required training was completed upon hire for one of one employee (unlicensed personnel (ULP)-F). 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	01380		

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01380	Continued From page 21 situation has occurred only occasionally). The findings include: ULP-F began employment on November 25, 2024, to provide direct care services to residents. On April 15, 2025, at 9:45 a.m., the surveyor observed ULP-F change out a portable oxygen tank for R2. ULP-F's employee record lacked documentation of the following training and competency evaluations to be completed by ULP: -observing, reporting, and documenting of resident status -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel -reading and recording temperature, pulse, and respirations of the resident -recognizing physical, emotional, cognitive, and developmental needs of the resident -safe transfer techniques and ambulation -range of motioning and positioning -administering medications or treatments as required On April 15, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A stated they were sure ULP-F completed all his training, there just isn't documentation of it in his record. They have been through many nurse and leadership changes and some documents are just missing. On April 15, 2025, at 3:08 p.m., ULP-F stated he did have all his required training, both on the computer and with the registered nurse. ULP-F further stated he had to demonstrate competency	01380		

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01380	Continued From page 22 to the nurse for the training including medication administration, oxygen management, and blood glucose monitoring. The licensee's Assisted Living Orientation- ULP Staff policy dated June 19, 2023, indicated newly hired unlicensed personnel will receive orientation and training on topics required by Minnesota statutes and rules for assisted living organizations which includes the above missed training. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=D	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); (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,	01470		

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01470	Continued From page 23 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 staff member 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 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	01470		

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01470	Continued From page 24 review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for one of two employees (unlicensed personnel (ULP-F). 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: ULP-F was hired on November 25, 2024, to provide direct care services to residents at the assisted living facility. On April 15, 2025, at 9:45 a.m., the surveyor observed ULP-F change out a portable oxygen tank for R2. ULP-F's employee records lacked the following required orientation content: -overview of assisted living statutes -handling of resident's complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints -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 -a review of the types of assisted living services	01470		

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01470	Continued From page 25 the employee will be providing and the facility's category of licensure On April 15, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A stated they were sure ULP-F completed all his training, there just isn't documentation of it in his record. They have been through many nurse and leadership changes and some documents are just missing. The licensees New Employee Orientation and Continuing Education policy dated April 2025, indicated the community provides orientation and training to new employees and continuing educations opportunities annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff received dementia training in the required areas for one of two employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01490		

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	30745	A. BUILDING: _____ B. WING _____	04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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
01490	Continued From page 26 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: ULP-F began employment on November 25, 2024, to provide direct care services to residents. On April 15, 2025, at 9:45 a.m., the surveyor observed ULP-F change out a portable oxygen tank for R2. ULP-F's employee record lacked evidence of completing dementia care training in the following topics: - an explanation of Alzheimer's disease and other dementia's - assistance with activities of daily living - problem solving with challenging behaviors - communication skills On April 15, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A stated they were sure ULP-F completed all his training, there just isn't documentation of it in his record. They have been through many nurse and leadership changes and some documents are just missing. The licensee's Dementia Training policy dated April 2025, indicated direct care staff will complete a minimum of 8 hours of initial training on dementia care topics. Dementia care training will include: An explanation of Alzheimer's disease and other dementias	01490		

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01490	Continued From page 27 Assistance with activities of daily living Problem solving with challenging behaviors Communication skills Person centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees, unlicensed personnel (ULP)-F received the required eight hours of dementia care training in the required time frame.	01540		

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01540	Continued From page 28 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: ULP-F began employment on November 25, 2024, to provide direct care services to residents. On April 15, 2025, at 9:45 a.m., the surveyor observed ULP-F change out a portable oxygen tank for R2. ULP-F's employee records indicated ULP-F did not complete the required number of hours of dementia training. On April 15, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A stated they were sure ULP-F completed all his training, there just isn't documentation of it in his record. They have been through many nurse and leadership changes and some documents are just missing. The licensee's Dementia Training policy dated April 2025, indicated direct-care staff will complete a minimum of 8 hours of initial training on dementia topics and initial training will be completed within 80 working hours of the employment start date. No further information was provided.	01540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01540	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed an ongoing reassessment and monitoring on or before day 90 for two of three residents (R1, R3).	01620		

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01620	Continued From page 30 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: On April 14, 2025, at 10:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated a registered nurse completed assessments pre-admission, at 14 days, every 90 days, and with changes in condition. R1 began receiving services on April 1, 2020. R1's record included a 90-day assessment dated December 15, 2024, and a 90-day assessment dated April 15, 2025, 31 days after the 90-day assessment was due. R3 began receiving services on November 16, 2016. R3's record included a 90-day assessment dated December 10, 2024, and a 90-day assessment dated April 16, 2025, 37 days after the 90-day assessment was due. On April 16, 2025, at 2:40 p.m., clinical nurse supervisor (CNS)-B stated she was aware of the late assessments because when they switched electronic medical record systems all the nursing assessments were completed at that time which made them all due at the same time. They have hired extra nursing to get these caught up and will stagger the assessments to keep this from happening again.	01620		

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01620	Continued From page 31 The licensee's Assessment Timing- AL policy dated April 2025, indicated all clinical assessments or UDAs will be completed per the federal and state-specific guidelines. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and	01940		

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01940	Continued From page 32 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 a treatment or therapy management plan to include the required content for three of three residents (R1, R3, R4). 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 the residents). The findings include: R1 was admitted on April 1, 2020. R1's medication administration record dated April 2025, indicated R1 received blood sugar checks four times daily. On April 14, 2025, at 12:10 p.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood glucose. R1's record lacked evidence of an individualized treatment or therapy management plan which included the following for assistance with blood glucose monitoring:	01940		

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01940	Continued From page 33 - documentation of specific resident instructions relating to the treatments or therapy administered -procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service R3 was admitted on November 16, 2016. R3's medication administration record dated April 2025, indicated R3 received blood glucose monitoring twice daily. R3's record lacked evidence of an individualized treatment or therapy management plan which included the following for assistance with blood glucose monitoring: -documentation of specific resident instructions relating to the treatments or therapy administered. -procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service R4 was admitted on December 13, 2023. R4's nursing assessment dated March 16, 2025, indicated R4 received assistance with oxygen management, compression stockings, and blood glucose monitoring. R4's record lacked evidence of an individualized treatment or therapy management plan which included the following: -documentation of specific resident instructions relating to the treatments or therapy administered -assistance with compression stocks not included on the service plan -procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service	01940		

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01940	Continued From page 34 On April 16, 2025, at 10:40 a.m., clinical nurse supervisor (CNS)-B stated the medication administration records, and treatment administration records should have specific instructions for blood glucose monitoring, oxygen management, and compression stockings and for any treatments for when to notify a nurse. The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated June 18, 2023, indicated the RN will develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. The treatment and therapy management plan will include: a. Statement of the type of service(s) provided b. Documentation of specific resident instructions relating to the treatments and/or therapy administration c. Identification of treatment or therapy tasks that may be delegated to an unlicensed staff member. d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments and/or therapy services e. 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 and/or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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02040	Continued From page 35	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted April 14, 2025, at 12:30 p.m., with licensed assisted living director (LALD)-A, director of maintenance (DM)-D, and	02040		

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	30745	A. BUILDING: _____ B. WING _____	04/16/2025

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02040	Continued From page 36 regional maintenance (RM)-E, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property and building. A hazard vulnerability assessment or safety risk must be performed on and around the property in assisted living with dementia care facilities. The hazards indicated on the assessment must be assessed and mitigated to protect residents from harm. During an interview on April 14, 2025, at 12:35 p.m., RM-E, stated they had a form for the HVA including mitigation factors but the HVA had not been performed and documented on and around the property and building. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date 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	02310		

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02310	Continued From page 37 standards, medical, or nursing standards for one of one resident (R2) who utilized oxygen. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On April 15, 2025, at 8:40 a.m., the surveyor observed three small portable oxygen tanks unsecured in R2's room. On April 15, 2025, at 8:40 a.m., licensed practical nurse (LPN)-G stated the tanks should be secured in racks and will call and order one right away. Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. The licensee's Oxygen Storage policy dated April 16, 2025, indicated oxygen cylinders used should be stabilized and stored properly in the oxygen storage area when not in use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/14/25*
Time: 11:30:00
Report: 1025251083

Food and Beverage Establishment Inspection Report

Location:
Lino Lakes Assisted Living Llc
725 Town Center Parkway
Lino Lakes, MN55014
Anoka County, 02

Establishment Info:
ID #: 0039255
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7632676183
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.

5-200B Plumbing: cross connections

5-203.14I ***** Priority 1 *****

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

Remove the wye adapter from the mop sink faucet, provide a backflow device or shorten hose above flood rim of sink, ensure the AVB on faucet works (hard water stains indicate leak, water leaking from fitting suggesting constant back pressure)

Comply By: 04/30/25

4-600 Cleaning Equipment and Utensils

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

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

5/23/22: (Repeat)
Discussed W/R/S of can opener blade, keep a flat head screwdriver on hand to remove the screws and the blade for sanitizing, wash the handle as needed to keep clean

Comply By: 05/23/22

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

Post the CFPM certificate in the establishment (with licenses or in kitchen office OK)

Comply By: 04/18/25

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.

Calibrate the rinse pressure gauge,or if accurate, adjust machine so rinse water is 180 deg F (read < 180 deg F during test, but the dial #s were tilted)

Comply By: 04/18/25

6-200 Physical Facility Design and Construction

6-202.15A

MN Rule 4626.1395A Seal holes, gaps, and other openings along floors, walls and ceilings to the outside of the building and provide self-closing, tight-fitting doors and windows for all outside openings.

Provide a section of door sweep missing (~ 4" by the sink side of the door bottom) to reduce possible entry of pests

Replace damaged floor cove by door

Comply By: 04/30/25

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Quaternary Ammonia: = 300 PPM at Degrees Fahrenheit
Location: 3 comp sink
Violation Issued: No

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: Memory care dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Soup
Temperature: 145 Degrees Fahrenheit - Location: Steam table
Violation Issued: No

Process/Item: Mashed potato
Temperature: 140 Degrees Fahrenheit - Location: Cooked for hot holding
Violation Issued: No

Process/Item: Diced tomato
Temperature: 40 Degrees Fahrenheit - Location: Prep table
Violation Issued: No

Process/Item: Yogurt
Temperature: 40 Degrees Fahrenheit - Location: Upright cooler
Violation Issued: No

Type: Full
Date: *04/14/25*
Time: 11:30:00
Report: 1025251083
Lino Lakes Assisted Living Llc

Food and Beverage Establishment Inspection Report

Process/Item: Pasta
Temperature: 40 Degrees Fahrenheit - Location: Walk in cooler
Violation Issued: No

Process/Item: Ambient
Temperature: 42 Degrees Fahrenheit - Location: Upright cooler memory care
Violation Issued: No

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

Memory care kitchen not in use during inspections due to COVID 19 in the facility

For the nail brush, if the facility would like to keep and use it, set it up so it can be removed from the tie, leaving in a small container of sanitizer solution, and W/R/S the brush through the dish machine. Chili on stove and opened can black beans for prep after lunch, heat to 165 within 2 hours from opening. Maintain yellow dish machine puck in the main kitchen since the memory care kitchen is chlorine.

If milk and TCS foods are maintained out of room temperature for meal service, complete the TPHC form and follow time marking requirements
Search "MDH TPHC"
https://www.health.state.mn.us/communities/environment/food/docs/fs/tphcfs.pdf
https://www.health.state.mn.us/communities/environment/food/docs/fs/tphcform.pdf

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 1025251083 of 04/14/25.

Certified Food Protection Manager Ray T

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Casey Kipping
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
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