Electronically Delivered

April 5, 2023

Licensee
Chev's Place LLC
13902 Jasmine Way
Rogers, MN 55374

RE: Project Number(s) SL33610015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 10, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796
JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33610	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEV'S PLACE LLC	13902 JASMINE WAY ROGERS, MN 55374

(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: #SL33610015 On March 6, through March 9, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 7 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the	0 485		

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0 485	Continued From page 1 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer residents a meal plan choice to pay for fewer meals or identify the numeric value of declined meals in their assisted living contract for one of one resident (R1). 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 or has potential to affect a large portion or all of the residents). The findings include: R1's Meal/Food Plan document dated August 1, 2021, indicated two options: three meals and two	0 485		

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0 485	Continued From page 2 snacks (included) would be provided to residents or no meal plan. R1's Meal/Food Plan Addendum also indicated charges pursuant resident's meal plan selection will be included in resident's monthly bill. On March 6, 2023, at approximately 12:55 p.m., licensed assisted living director (LALD)-A indicated the facility receives community access disability inclusion (CADI) reimbursement for all residents receiving the licensee's meal plan. LALD-A also indicated all residents are required to sign the Meal/Food Plan addendum at the time of move in, and licensee did offer the residents an option for no meals, but not an option for fewer meals, as the meal plan options are all or nothing. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
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	0 680		

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0 680	Continued From page 3 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 observation, interview, and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 6, 2023, at approximately 1:15 p.m., licensed assisted living director (LALD)-A provided a binder and indicated the contents were the licensee's EP plan. The licensee's EP plan dated August 1, 2021, lacked: -documentation of annual review;	0 680		

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0 680	Continued From page 4 -documentation of missing resident quarterly review; -policies and procedures on medical documents and volunteers; and -emergency prep training and testing as required per Appendix Z. On March 7, 2023, at approximately 1:30 p.m., LALD-A acknowledged the licensee's emergency preparedness plan lacked the above listed required content, and was not aware of the required content of Appendix Z. The licensee's Emergency Preparedness policy dated July 21, 2021, indicated the licensee's EP would include all required elements of Appendix Z. Additionally, the plan would be in writing and reviewed annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	0 780		

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0 780	Continued From page 5 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 7, 2023, between 10:30 a.m. and 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A and the owner (O)-E. During the facility tour, survey staff observed that smoke alarms were not installed in two resident sleeping rooms in the basement.	0 780		

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0 780	Continued From page 6 Further observation identified upon testing, that the vacant basement sleeping room was equipped with a smoke alarm that was not interconnected with the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. These deficient conditions were verified by the LALD-A and O-E accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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 record review and interview, the licensee failed to develop fire safety and evacuation plans with the required elements and failed to complete required employee evacuation drills. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 800		

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0 800	Continued From page 7 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 March 7, 2023, between 10:30 a.m. and 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A and the owner (O)-E. During the facility tour, survey staff observed that the location of all resident sleeping rooms was not identified on the evacuation plans posted in the facility. On March 7, 2023, at approximately 11:30 a.m., records were provided for review. Records were reviewed by survey staff on March 7, 2023, between 11:30 a.m. and 12:45 p.m. Record review indicated that the fire safety and evacuation plans had not been developed for the facility location and did not include the following required elements: 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; 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. Additionally, the Fire Safety Policy instructions include evacuating using egress options identified on the evacuation plan, but these egress options are not identified or described.	0 800		

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0 800	Continued From page 8 Record review of the available documentation indicated that evacuation drills for employees had not been performed. The fire drill log was blank. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On March 7, 2023, at approximately 1:00 p.m., the LALD-A and O-B verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff.	0 820		

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0 820	Continued From page 9 This practice resulted in a level two violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was 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). On March 7, 2023, between 10:30 a.m. and 11:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A and the owner (O)-E. During the facility tour, survey staff observed a deadbolt lock installed on a designated exit door where a key fob system was installed and used as the primarly method to unlock the door. In the event of an evacuation, exit doors with both a key fob system and deadbolt lock would prevent a safe and quick exit. This deficient condition was verified by the LALD-A and O-E accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
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	0 970		

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0 970	Continued From page 10 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 licensee'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 or has potential to affect a large portion or all of the residents). The findings include: On March 6, 2023, at approximately 12:20 a.m., licensed assisted living director (LALD)-D provided a blank Assisted Living Contract and indicated the current contract is used by licensee for all residents who lived in the facility. The licensee's Assisted Living Contract, undated, on page 15, included a section titled 4. Liability and read, "Provider is not liable to Resident for any injury, death or property damage occurring in the Unit or on Provider's premises." On March 7, 2023, at approximately 2:00 p.m., during the exit conference, LALD-D stated the licensee's assisted living contract included a waiver of liability for health and safety or personal property of the resident. LALD-D stated the liability waiver would need to be removed from all	0 970		

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0 970	Continued From page 11 contracts, and resigned by all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	Continued From page 12 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 licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative, and the Office of Long-Term Care (OOLTC) for one of one resident (R2) who had an emergency relocation. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted on May 8, 2021. R2's Progress Notes dated January 18, 2023, at 4:31 p.m., indicated R2 was transported and admitted to the hospital.	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33610	A. BUILDING: _____ B. WING _____	03/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHEV'S PLACE LLC	13902 JASMINE WAY ROGERS, MN 55374

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01060	Continued From page 13 R2's Progress Notes dated January 31, 2023, at 2:05 p.m., indicated there is no anticipated discharge date yet for R2. R2's progress notes lacked identification of R2's return to the facility. R2's record lacked documentation licensee provided an emergency relocation written notification as required to the resident, legal representative, designated representative, and the OOLTC. On March 7, 2023, at approximately 1:45 p.m. clinical nurse supervisor (CNS)-B indicated the licensee was not aware of the required content of an emergency relocation notice and the licensee had not provided the notice to the Ombudsman when the emergency relocation was longer than four days. The licensee's Discharge and Transfer of Residents policy dated July 22, 2021, under the section Emergency Relocation, indicated the required written notice with the required content for an emergency relocation would be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=C	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	01290		

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	33610	A. BUILDING: _____ B. WING _____	03/10/2023

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01290	Continued From page 14 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under 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 a clearance received in affiliation with the assisted living with dementia care licensee's current health facility identification (HFID) for one of one employee (licensed practical nurse (LPN)-C). 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 or has potential to affect a large portion or all of the residents). The findings include: LPN-C was hired on May 23, 2019. On March 6, 2023, at approximately 11:35 a.m., the surveyor observed LPN-C performed resident cares. LPN-C's employee record included a background study clearance, affiliated with the licensee's former comprehensive HFID license #32771.	01290		

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01290	Continued From page 15 Although the licensee converted from comprehensive license to assisted living licensee on August 1, 2021, licensee continued to submit background checks under the comprehensive license. LPN-C's employee records lacked evidence of current, cleared background studies affiliated with the licensee's current assisted living with dementia care HFID license #33610, effective August 1, 2021. On March 6, 2023, at approximately 2:20 p.m., licensed assisted living director (LALD)-A indicated the background studies for licensee's employees were conducted under licensee's comprehensive HFID license #32771 versus the new assisted living license HFID #33610. The licensee's Recruitment and Hiring policy dated July 22, 2021, indicated licensee complies with all state regulations for pre-employment background checks/studies required for all employees. Additionally, all new hires must have a completed background prior to having contact with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

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01640	Continued From page 16 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by resident or resident representative to document agreement on the services to be provided 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, 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:	01640		

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01640	Continued From page 17 R1 was admitted on January 25, 2019. R1's Service Plan Addendum to the Assisted Living Contract signed January 13, 2022, was identified by clinical nurse supervisor (CNS)-B as R1's most currently authenticated service plan. R1's Service Plan Addendum to the Assisted Living Contract dated March 7, 2023, was provided by CNS-B, and indicated as R1's current service plan with services R1 was receiving. The service plan included 15 identified services which were revised after the signed service plan dated January 13, 2022. The following service plan revisions identified: -ambulation/exercise removed; -HHA tasks special added; -housekeeping from two days to one day a week; -laundry from two days to one day a week; -laundry two days a week removed; -medication administration from eight times to seven times per day; -medication reminder three times per day removed; -medication setup three days a week added; -record - blood glucose three days a week added; -record - pulse from one day a week to two times per day; -skin care two times per day removed; -skin check from one to two times per day; -record blood glucose from every 45 days to every 60 days; -record blood pressure every 90 days added; and -transfer/mobility status five times per day added. On March 7, 2023, at approximately 10:10 a.m., CNS-B indicated the licensee's expectation is all current service plans are signed by the RN who completed the document and then the resident or	01640		

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01640	Continued From page 18 the resident's designated representative. CNS-B indicated licensee had completed R1's service plan but was unsure why licensee did not sign or obtain the resident's authentication after revisions. The licensee's Service Plan policy dated July 22, 2021, indicated any changes to the resident's service plan or agreement must be signed by the resident or the resident's representative and the licensee's representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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 safety risk assessment or hazard vulnerability assessment of the physical environment on and around the	02040		

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02040	Continued From page 19 property with mitigation factors. 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 the potential to affect a large portion or all of the residents). Findings include: On March 7, 2023, at approximately 11:30 a.m., records were provided for review. Records were reviewed by survey staff on March 7, 2023, between 11:30 a.m. and 12:45 p.m. A hazard vulnerability assessment was included in the Emergency Preparedness Manual, but this assessment did not identify safety risks or hazards on and around the property for the physical environment with mitigation factors. On March 7, 2023, at approximately 1:00 p.m., the LALD-A and O-B verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:	02110		

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02110	Continued From page 20 (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to one of one resident (R1). This practice resulted in a level one violation (a	02110		

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02110	Continued From page 21 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 or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on January 25, 2019. R1's records lacked documentation they or their designated representatives received the required policies and procedures (P/P) to be provided. On March 7, 2023, at 1:15 p.m., licensed assisted living director (LALD)-A indicated the licensee was aware the identified policies and procedures were required to be provided to the residents at the time of move in. LALD-A stated although the licensee had developed the required P/P, but the licensee failed to provide the P/P to any resident who resided in the facility. The licensee's Policies Specific to Assisted Living with Dementia Care policy dated July 22, 2021, indicated policies and procedures shall be provided by the licensee to the resident and the resident's legal and designated representatives at the time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *03/07/23*
Time: 16:00:00
Report: 8087231048

Food and Beverage Establishment Inspection Report

Location:
Chev'S Place Llc
13902 Jasmine Way
Rogers, MN55374
Hennepin County, 27

Establishment Info:
ID #: 0038046
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634441881
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 37 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP FRIDGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 7 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

Type: Full
Date: *03/07/23*
Time: 16:00:00
Report: 8087231048
Chev'S Place Llc

Food and Beverage Establishment Inspection Report

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

FLOORS AND CABINETS ARE HARDWOOD AND CEILING APPEARS TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

WHIRLPOOL BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

KITCHEN HAS DESIGNATED HANDWASHING SINK.

INSPECTION REPORT EMAILED TO NURSE EVALUATOR CARL SAMROCK (HE/HIM/HIS).

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 8087231048 of 03/07/23.

Certified Food Protection Manager: AMANDA M. HOGENDORF

Certification Number: FM111025 Expires: 12/07/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
AMANDA M. HOGENDORF
KITCHEN MANAGER

Signed: _____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us