Electronically Delivered

August 4, 2023

Licensee
Summerwood Of Plymouth
16205 36th Avenue North
Plymouth, MN 55446

RE: Project Number(s) SL30236015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

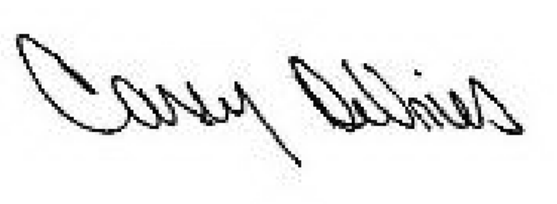
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd.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

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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
	30236	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF PLYMOUTH	16205 36TH AVENUE NORTH PLYMOUTH, MN 55446

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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: SL30236015-0 On July 10, 2023, through July 12, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 114 active residents; 50 of whom received services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving, hand hygiene, and catheter care for four of five employees (unlicensed personnel (ULP)-B, ULP-E, ULP-M, and ULP-N). 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: ULP-B ULP-B was hired on March 31, 2023, to provide direct cares and services to residents. On July 11, 2023, at 7:37 a.m., the surveyor observed ULP-B, without performing hand	0 510		

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0 510	Continued From page 2 hygiene, apply gloves, administer medications to R10, and doff (remove) gloves. Without performing hand hygiene, ULP-B escorted R10 to the dining room for breakfast. On July 11, 2023, at 8:01 a.m., the surveyor observed ULP-B, without performing hand hygiene, apply gloves, make R14's bed, and arrange the room. Without performing hand hygiene or a change in gloves, ULP-B prepped and administered medications to R14, exited R14's apartment, walked into the hallway, through the kitchen, doffed gloves, and performed hand hygiene. On July 11, 2023, at 9:15 a.m., the surveyor observed ULP-B, without performing hand hygiene, apply gloves, prepare medication, and administer medications to R4. Using the same gloves, ULP-B assisted R4 to change from a night catheter bag to a leg bag, then took the night catheter bag into the bathroom and hung the bag that contained urine on the rail without draining the bag. ULP-B still using the same gloves, assisted R4 to remove a soiled brief, provided perineal care, applied moisture barrier cream to R4's groin area and buttock, assisted with dressing, and transferred R4 into the wheelchair. On July 11, 2023, at 11:30 a.m., ULP-B stated they were trained and were supposed to complete hand washing before and after cares. ULP-B also stated they had not worked with the residents before, and this made her more nervous when completing cares. ULP-E ULP-E was hired on October 21, 2022, to provide direct cares services to residents.	0 510		

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0 510	Continued From page 3 On July 11, 2023, from 7:30 a.m. to 8:01 a.m., during continuous observation, the surveyor observed ULP-E enter R2's room and without performing hand hygiene applied clean gloves. ULP-E then assisted R2 with blood glucose testing via setup. Without changing gloves, ULP-E cleaned injection site with alcohol wipe and administered insulin via subcutaneous injection to lower left quadrant of R2's abdomen. ULP-E assisted R2 into the bathroom via stand by assist. Surveyor observed ULP-E remove soiled gloves, and without performing hand hygiene, applied a new pair of gloves. ULP-E then set up and administered morning oral medications to R2. Upon leaving R2's room, the surveyor observed ULP-E removing soiled gloves, and performing hand hygiene using hand sanitizer. On July 11, 2023, at 8:02a.m. to 8:24 a.m., during continuous observation, the surveyor observed ULP-E enter R6's room. Without performing hand hygiene or applying clean gloves, ULP-E set up and administered morning medications to R6. Without performing hand hygiene, ULP-E applied clean gloves to administer eye drops to R6. ULP-E removed gloves and did not perform hand hygiene. On July 11, 2023, at 8:27 a.m., ULP-E indicated that infection control training was provided by the licensee at the corporate office and in online training modules. On July 11, 2023, at 8:28 a.m. to 9:00 a.m., during continuous observation, the surveyor observed ULP-E enter R7's room. Without performing hand hygiene, ULP-E applied clean gloves and assisted R7 with tidying of room. The	0 510		

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0 510	Continued From page 4 surveyor observed ULP-E performing hand hygiene at sink prior to applying clean gloves. ULP-E then setup and administered morning nebulizer treatment to R7. Upon completion of nebulizer treatment, ULP-E rinsed nebulizer cup at sink. ULP-E removed gloves and then performed hand hygiene at sink. Without donning (applying) gloves, the surveyor observed ULP-E set up and administer morning medications to R7. Without performing hand hygiene, ULP-E applied clean gloves and administered an additional nebulizer treatment. Nebulizer cup rinsed at sink. ULP-E then removed gloves and performed hand hygiene at sink. On July 11th, 2023, at 9:05 a.m., ULP-E indicated that infection control training provided by licensee covered information on hand washing. ULP-E indicated that per training provided, hands are to be washed in between cares, and in between glove changes. ULP-M ULP-M started employment with licensee on August 19, 2021, to provide direct cares and services to residents. On July 11, 2023, from 7:22 a.m. to 7:58 a.m., during continuous observation, the surveyor observed ULP-M perform cares and administer medications to residents in the licensee's secured unit. The surveyor observed ULP-M enter R16's room and wash hands, then ULP-M left the room to obtain blood pressure machine. ULP-M returned to R16's room with blood pressure machine, and without performing hand hygiene or donning gloves, ULP-M checked R16's blood pressure, set up and administered medications, assisted	0 510		

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0 510	Continued From page 5 R16 with walking into the bathroom, dressing, tooth brushing, and combing of hair. ULP-M tidied the room, and walked R16 to the dining room. Without any additional hand hygiene, ULP-M left the unit to obtain breakfast for residents from the kitchen. ULP-N ULP-N started employment with licensee on March 22, 2010, to provide direct cares and services to residents. On July 11, 2023, from 8:03 a.m. to 8:52 a.m., during continuous observation, the surveyor observed ULP-N enter R11's room and wash their hands at the sink. ULP-N donned gloves, set up and administered R11's oral medications and eye drops, removed gloves, and exited the room without performing hand hygiene. On July 11, 2023, at 9:45 a.m., ULP-M stated they had been trained on handwashing and that hands should be washed before and after taking care of residents. On July 12, 2023, at 11:20 a.m., clinical nurse supervisor (CNS)-C stated hand hygiene was to be completed before cares, after cares, before applying clean gloves and in between glove changes. On July 12, 2023, at 11:32 a.m., CNS-C stated all ULPs are trained to wash hands before and after gloving to provide cares in each resident room and before serving food. The licensee's undated Infection Control policy indicated appropriate hand hygiene is essential in preventing transmission of infectious agents. Hand hygiene includes hand washing with soap	0 510		

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0 510	Continued From page 6 and water and hand hygiene with alcohol-based hand rub. Also indicated hand hygiene should be performed: a. before and after contact with the resident b. before performing an aseptic task c. after contact with blood or body fluids d. after contact with visibly contaminated surfaces e. after contact with objects in the resident ' s room f. before donning personal protective equipment g. after removing personal protective equipment h. after using the restroom i. before meals The Centers for Disease Control's (CDC), "CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings" dated November 29, 2022, under section 5a.2 read: 2.) Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a.) Immediately before touching a patient; b.) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c.) Before moving from work on a soiled body site to a clean body site on the same patient; d.) After touching a patient or the patient's immediate environment; e.) After contact with blood, body fluids or contaminated surfaces; and f.) Immediately after glove removal. The licensee's Hand Washing policy dated August 1, 2021, read, "Hand Hygiene and Gloves: When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves."	0 510		

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0 510	Continued From page 7 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 680		

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0 680	Continued From page 8 content. In addition, the licensee failed to comply with the frequency of inspections and load test requirements for the facility's emergency power system (permanent generator) as part of the facility's emergency disaster and preparedness plan as required under Minnesota Rules, Part 4659.0100. This had the potential to affect all residents receiving services under the assisted living with dementia license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - quarterly review of missing resident policy; - annual review of EPP; - policy defining established emergency program; - communication plan containing all required elements; - annual review of communication plan; - consideration for emerging infectious diseases; - P/P for system to track the location of on-duty staff and relocated residents; - P/P to address system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - names, primary, and alternate contact information: staff, entities providing services	0 680		

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0 680	Continued From page 9 under agreement, residents' physicians, other facilities, and volunteers; and - means of providing information about general condition and location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). On July 10, 2023, at 2:15 p.m., licensed assisted living director (LALD)-D stated reviews of the Missing Resident Policy would occur annually. On July 10, 2023, at 2:15 p.m., the surveyor discussed list of content not found during review of EPP with LALD-D. Over the next two days LALD-D provided multiple items from content list that were not initially in EPP binder but were present at facility. The EPP still lacked the information noted above at conclusion of survey on July 12, 2023 at 2:30 p.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	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	0 780		

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0 780	Continued From page 10 separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in an individual sleeping unit of the facility. This deficient condition had the ability to affect a limited number of staff 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 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on July 12, 2023, at approximately 12:00 p.m. with environmental services director (ESD)-H and regional engineering manager (REM)-I it was observed	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30236	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF PLYMOUTH	16205 36TH AVENUE NORTH PLYMOUTH, MN 55446

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0 780	Continued From page 11 that a smoke alarm was not installed in resident room 138. Smoke alarms are required to be inside each sleeping unit throughout the facility. This deficient finding was visually and verbally verified by ESD-H and REM-I at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) 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 observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair 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) 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).	0 800		

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	30236	A. BUILDING: _____ B. WING _____	07/12/2023

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0 800	Continued From page 12 Findings include: On a facility tour on July 12, 2023, at approximately 12:30 p.m. with environmental services director (ESD)-H and regional engineering manager (REM)-I it was observed that the covers for the removed electrical meters at the old meter bank in the garage were coming off and exposing electrical connections inside the box. It was observed that an extension cord was being used permanently to power the sump pump in electrical room TR-1 across corridor from wellness room in lower level. Electrical extension cords are required to be used according to the manufacturer's instructions and only for temporary use. The main commercial laundry room fire resistant rated door was observed held open with a devise that does not release to close upon activation of the building fire alarm system. Several other fire-resistant rated doors in the facility were observed with devises to hold the door open that do not release to close upon activation of the fire alarm system. The fire-resistant rated doors are required to be kept closed as designed and installed at the time of construction approval. Storage of garbage cans and cabinets were observed in the marked means of egress corridor near resident room 158 on the facility tour. Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants and emergency responders during an emergency. These deficient conditions were visually verified	0 800		

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0 800	Continued From page 13 by ESD-H and REM-I accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810		

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	30236	A. BUILDING: _____ B. WING _____	07/12/2023

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0 810	Continued From page 14 drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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). Findings include: A record review of available documentation and interview were conducted on July 12, 2023, at approximately 10:30 a.m. of documents provided by licensed assisted living director (LALD)-D, environmental services director (ESD)-H and regional engineering manager (REM)-I on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that employees received training but not in the required sequence. Employee training is required upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Employee training is required to be documented separately from drills.	0 810		

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0 810	Continued From page 15 All deficiencies were verified by LALD-D, ESD-H and REM-I during the interview at approximately 1:30 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living within the assisted living with dementia care facility. 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:	0 970		

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0 970	Continued From page 16 On July 10, 2023, at approximately 11:10 a.m., licensed assisted living director (LALD)-D provided the surveyor a blank Residency Agreement and stated the resident agreement was used by the licensee for all residents. The blank resident agreement included the following two sections which included language waving the facilities liability for health, safety, or personal property of a resident: Page 15: section k "Be responsible for the costs associated with the following, caused by the acts or failure of Resident, pets, Resident's agents, family members, or guests, whether Intentional or unintentional, and whether or not under Resident's control or direction: 1) any loss, property damage, or repair or service (including plumbing problems) or injury to any person, 2) any loss or damage caused by Inappropriate use of any feature of the Apartment, Including as examples only and without limitation, doors or windows being left open, faucets being left open, toilet use, stoves being left on, and refrigerators being left open." On July 12, 2023, at 9:40 a.m., LALD-D stated the blank Residency Agreement provided to the surveyor was used for all residents who received services. LALD-D also stated licensee was aware of the statements but did not think it was a waiver of liability and intended to request reconsideration for the waiver correction order. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

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	30236	A. BUILDING: _____ B. WING _____	07/12/2023

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

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01060	Continued From page 18 (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 required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one of one resident (R13). 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: R13 was admitted to the licensee on April 13, 2022, and began receiving assisted living services. R13's Service Plan - Attachment E to Residency Agreement signed March 1, 2023, indicated R13 received assistance with toileting one to six times per day, tray delivery, showers, housekeeping, laundry, continuous positive airway pressure (CPAP) machine management twice daily, and medication management. R13's Resident Profile- Notes- RTasks dated April 14, 2023, indicated R13 was inpatient at	01060		

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01060	Continued From page 19 Methodist hospital with discharge plans to go to a transitional care unit (TCU). R13's Order Summary Report from Good Samaritan Society dated May 15, 2023, indicated R13 was admitted to Good Samaritan Society-Ambassador Post-Acute Care Unit on April 16, 2023. R13's Good Samaritan Society Post-Acute Care Unit Discharge Orders dated May 19, 2023, indicated R13 was discharging back to licensee on May 19, 2023. R13's record lacked a written notice delivered to the resident or designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for OOLTC; - 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 - 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. In addition, R13's record lacked notification to OOLTC when R13 did not return to the facility within four days. On July 12, 2023, at 3:49 p.m., clinical nurse supervisor (CNS)-C stated R13's record lacked a written emergency relocation notice. CNS-C	01060		

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01060	Continued From page 20 stated this was being addressed as an area of improvement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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	01620		

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	30236	A. BUILDING: _____ B. WING _____	07/12/2023

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01620	Continued From page 21 licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for three of three residents (R2, 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 of the residents). The findings include: R2 R2 admitted to the licensee on March 25, 2016, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R2's diagnosis included diabetes type 2. R2's Service Plan - Attachment E to Residency Agreement signed September 25, 2022, indicated R2 received assistance with morning and evening standard assistance, housekeeping, and medication management. R2's record included 90-day nursing assessments dated March 22, 2023, and June 23, 2023. The assessment completed on June 23, 2023, indicated 93 days had passed between assessments. R3 R3 admitted to the licensee on March 14, 2022,	01620		

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01620	Continued From page 22 and began receiving assisted living services. R3's diagnoses included hypertension (HTN), parkinsonism, gait disorder, macular degeneration, diverticulosis of large intestine, asthma, anxiety, restless leg syndrome, obstructive sleep apnea, depression, degenerative joint disease, hearing loss, and breast cancer. R3's Service Plan - Attachment E to Residency Agreement signed March 7, 2023, indicated R3 received assistance with showers, morning and evening standard assistance, housekeeping, and medication management. R3's record included 90-day nursing assessments dated December 5, 2022, March 6, 2023, and June 7, 2023. The assessment completed on March 6, 2023, indicated 91 days had passed between assessments and the assessment completed on June 7, 2023, indicated 93 days passed between assessments. R4 R4 admitted to the licensee on December 1, 2004, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R4 diagnoses included dementia, bursitis, incontinence, bronchitis, and osteoarthritis. R4's Service Plan - Attachment E to Residency Agreement signed October 6, 2022, indicated R4 received assistance with medication management, monitoring and assessment by RN, bed mobility and repositioning, catheter care, homemaking, transfer assist with mechanical lift, and laundry.	01620		

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	30236	A. BUILDING: _____ B. WING _____	07/12/2023

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01620	Continued From page 23 R4's record included 90-day nursing assessments dated October 17, 2022, January 11, 2023, and April 18, 2023. The assessment completed on April 18, 2023, indicated 97 days passed between assessments. On July 12, 2023, at 11:29 a.m., clinical nurse supervisor (CNS)-C stated ongoing assessment should be completed every 90 days. The surveyor inquired why R2, R3, R4's ongoing assessments were conducted after 90 days. CNS-C stated they were unaware of the reason assessments were not completed by day 90 because they were not employed at the facility at the time the assessments were completed. In addition, CNS-C stated assessments could have been late if the assessment was due on a weekend or when a staff member took vacation. The licensee's MN AL Nursing Assessment Policy effective May 3, 2022, indicated a registered nurse (RN) would complete ongoing assessments of the resident's physical, mental, and cognitive needs periodically but no less than every 90-days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760		

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01760	Continued From page 24 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescribers orders were accurately transcribed for one of 14 residents (R9) and failed to ensure medications were administered as ordered for two of 14 residents (R9, R11). 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: R9 R9 admitted to the licensee on December 8, 2021, and began receiving assisted living services. R9's diagnosis included hypertension (HTN), macular degeneration, bilateral hearing loss, and transient ischemic attack (TIA) (commonly known	01760		

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	30236	A. BUILDING: _____ B. WING _____	07/12/2023

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01760	Continued From page 25 as a mini stroke). R9's Service Plan - Attachment E to Residency Agreement signed April 4, 2022, indicated R9 received assistance with housekeeping, medication administration, and medication management. On July 11, 2023, at 7:32 a.m., the surveyor observed unlicensed personnel (ULP)-F administer 1000 milligrams (mg) of vitamin C to R9. R9's provider orders signed November 12, 2021, included vitamin C 1000 mg give one pill daily. R9's provider orders signed February 2, 2022, included vitamin C 1000 micrograms (mcg) give one tablet one time per day indication supplement. On July 11, 2023, 7:48 a.m., the surveyor inquired what ULP-F would do if medication on the electronic devices's electronic medication administration record (EMAR) did not match the information on the medication card. ULP-F stated they would notify a nurse if the dosage did not match what was listed on the MAR. ULP-F verified R9's medication card did not match the MAR. The surveyor inquired why they did not contact a nurse prior to administering the medication. ULP-F stated, "I did not notice they did not match to be frank." On July 12, 2023, via email correspondence at 10:39 a.m., clinical nurse supervisor (CNS)-C stated a transcription error occurred when the nurse entered the medication order incorrectly into RTasks (a documentation software program) and R9 had been receiving the correct dose of	01760		

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01760	Continued From page 26 vitamin C 1000 mg for an unknown amount of time. On July 13, 2023, via email correspondence at 2:30 p.m., CNS-C stated the vitamin C dosage of 1000 mcg had been entered incorrectly since R9's admission. R11 R11 admitted to the licensee on July 5, 2022, and began receiving assisted living services. R11's diagnosis included vascular dementia, hypothyroidism, and HTN. R11's Service Plan - Attachment E to Residency Agreement signed October 6, 2022, indicated R11 received assistance with laundry, showering, verbal cueing for grooming and cares, bathroom assistance, medication administration, and medication management. R11's provider orders signed June 13, 2023, included Synthroid 75 mcg with directions to give one tablet by mouth one time daily thirty to sixty minutes before food and no bowel medications to be given with Synthroid. R11's medication administration record (MAR), dated July 1 to July 31, 2023, indicated Synthroid daily 75 micrograms (mcg) to give one tablet daily 30 to 60 minutes before food. On July 11, 2023, at 8:03 a.m., the surveyor observed ULP-N administer 75 mcg of Synthroid to R11 and assist R11 to the dining area where R11 was immediately served breakfast and began eating by 8:18 a.m. On July 12, 2023, at 10:15 a.m., ULP-N stated	01760		

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01760	Continued From page 27 they did not realize R11 had a medication that was to be given that long before breakfast. ULP-N stated R11 could have all of their medications earlier but ULP-N thought it would be too busy in the morning to ensure R11 did not eat anything for that long after medications were administered. On July 11, 2023, at 10:45 a.m., CNS-C indicated if the ULP are not following medication administration directions it would be identified on the weekly medication monitoring completed by a nurse. CNS-C stated the medication could be scheduled earlier to avoid breakfast time. The licensee's AL Medication Management Policy dated June 6, 2023, indicated administration of medication to the resident was based on provider orders. In addition, the ULP verified the medication set up delegated by RN or pharmacist were taken by the resident according to procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880		

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01880	Continued From page 28 review, the licensee failed to store prescription medication securely and permit only authorized personnel to have access for one of 14 residents (R4). In addition, the licensee failed to monitor the medication refrigerator temperature. This had the potential to affect all residents with refrigerated medications. 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: UNSECURED MEDICATIONS R4 R4's diagnoses included dementia, bursitis, incontinence, bronchitis, and osteoarthritis. R4's Service Plan - Attachment E to Residency Agreement signed October 6, 2022, indicated R4 received assistance with medication monitoring/management, medication administration, and monitoring and assessment by registered nurse (RN). In addition, the service plan indicated medications are kept in the apartment in a locked box or cabinet. On July 11, 2023, at 9:15 a.m., the surveyor observed on R4's nightstand by the bed the following medications unsecured: moisture barrier cream ointment, vitamin A & D diaper rash ointment, and USP normal saline.	01880		

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01880	Continued From page 29 On July 12, 2023, at 11:32 a.m., clinical nurse supervisor (CNS)-C stated all medications are supposed to be locked away in the cabinets and no medication should be left anywhere in the resident room. CNS-C further stated unlicensed personnel (ULP) probably left the medications unsecured after use. The licensee's AL Medication Management Policy dated June 6, 2023, indicated all medications will be stored in a locked box in a cabinet or refrigerator in the resident's unit in areas in which the temperature may not fluctuate to levels that are unsuitable for medication storage. FACILITY MEDICATION REFRIGERATOR On July 10, 2023, at 9:50 a.m., the surveyor observed the medication storage refrigerator. The medication refrigerator lacked the presence of a thermometer. No temperature log was observed to be on or near the medication refrigerator. The medication refrigerator contained multiple eye drops requiring temperature control for at least ten residents. On July 10, 2023, at 9:50 a.m., when asked about a method of checking the temperature of the medication refrigerator and a record of the temperature history, licensed practical nurse (LPN)- O stated, "We don't check the temperature of the fridge." On July 10, 2023, at 9:50 a.m., registered nurse (RN)-A and RN-P confirmed no mechanism of monitoring and recording the temperature of the medication refrigerator currently existed. On July 12, 2023, at 11:26 a.m. clinical nurse supervisor (CNS)-C stated the temperature of the medication refrigerator was not being monitored	01880		

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	30236	A. BUILDING: _____ B. WING _____	07/12/2023

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01880	Continued From page 30 and recorded. CNS-C stated, "we were not checking it, and I am already fixing this." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription labels included an expiration date for one of 14 residents (R9). In addition, the licensee failed to ensure to discard expired medication for three of 14 residents (R2, R4, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01890		

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01890	Continued From page 31 MEDICATION LABEL On July 11, 2023, at 8:00 a.m., the surveyor observed R9's medication cabinet located in resident's room. The cabinet contained two blister cards of AREDs 2 antioxidant supplements and one blister card of bupropion hydrochloride (hcl). The blister cards had a handwritten label which included the resident's name, medication name, strength of medication, and instructions for use of medication, however lacked an expiration date of medication. On July 11, 2023, at 8:18 a.m., the surveyor inquired how they look at the expiration dates on the medications listed above. Unlicensed personnel (ULP)-F requested the surveyor ask the nurse. In addition, ULP-F stated the residents only received the amount of medication needed between cycle fills (pharmacy automatically replenishing the routine medications for a facility) and "they do not last long in the cupboards." On July 11, 2023, at 9:02 a.m., clinical nurse supervisor (CNS)-C stated the licensee packaged medications in blister cards in house if they were received in bottles. The surveyor inquired if they write the expiration date on the blister cards. CNS-C stated the nurse packaging the medication should write the expiration date on the blister card and stated they may have forgot to add the expiration date and they will remind nurses to add the expiration date to the label when they package the medications. EXPIRED MEDICATION On July 11, 2023, at 7:30 a.m., the surveyor observed R2's medication cabinet located in the resident's room and observed the following expired medications:	01890		

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01890	Continued From page 32 - triamcinolone cream 0.1% - Expired March 4th, 2022. - nystatin powder- Expired June 13th, 2022. On July 11, 2023, at 9:09 a.m., the surveyor observed R8's medication cabinet located in the resident's room and observed the following expired medication: - mupirocin cream - Expired September 30th, 2022. On July 11, 2023, at 9:15 a.m., the surveyor observed R4's medication cabinet located in the resident's room and observed the following expired medication: - usp normal saline expired January 22, 2023. On July 11, 2023, at 0745 a.m., ULP-E stated nursing was in charge of managing the removal of expired medications stored in resident rooms. On July 12, 2023, at 11:20 a.m., CNS- C stated that nursing is responsible for managing the removal of expired medications from resident rooms and that ULPs are also expected to check expiration dates on medications and notify nursing. The licensee's AL Medication Management Policy dated March 6, 2023, indicated when a medication set-up occurred it required the resident name, medication name, medication dose, quantity of dose, times to be administered, route of administration, expiration date, and initials of the licensed nurse completing the set up to be added to the new label. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01890		

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01890	Continued From page 33 days	01890		
02070 SS=F	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests of residents for assistance in the secured unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license, which was comprised of one building with three levels. The first floor contained a secured unit. The licensee's current	02070		

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02070	Continued From page 34 census was 114 residents: 20 of whom resided in the secured unit. On July 11, 2023, at 6:50 a.m., unlicensed personnel (ULP)-J, an overnight employee, stated the licensee scheduled one ULP in the secured unit, one ULP in the unsecured unit, and one ULP to float between the two units. The surveyor inquired if two ULPs were ever scheduled to work the overnight shift. ULP-J stated they had heard two employees had worked on the overnight shift however, they had always worked with three ULPs. On July 11, 2023, at 6:52 a.m., ULP-K, an overnight employee, stated there were times where two ULPs worked the overnight shift. The surveyor inquired how many times this occurred. ULP-K stated two to three times since their date of hire. The surveyor inquired if they were working with two ULPs and a fall occurred in the unsecured unit what would they do. ULP-K stated if residents were asleep, they would leave the secured unit to assist the unsecured unit. On July 11, 2023, at 6:57 a.m., the surveyor inquired who the ULP would contact if a fall occurred in the overnight hours. ULP-L, an overight employee, stated if there were two ULPs in the secured unit and one ULP in the unsecured unit and they would contact the second ULP in the secured unit to assist. The surveyor inquired if they had worked on an overnight shift with two ULPs scheduled. ULP-L stated they did once in April. The surveyor inquired what the ULP would do if there was a fall in the unsecured unit and two ULPs were scheduled to work. ULP-L stated the secured unit ULP would assist in the unsecured unit and then return to the secured unit.	02070		

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02070	Continued From page 35 The surveyor reviewed the staffing schedule for the overnight shift from March 26 to July 11, 2023, which indicated the overnight shift had two ULPs scheduled, one ULP in the secured unit and one ULP on the unsecured unit, one time within the period reviewed. In addition, the staffing schedule indicated overnight shift was 11:00 p.m. to 7:00 a.m. The surveyor reviewed the licensee's falls history for the last six months which indicated no falls occurred in the overnight hours on the day only two ULPs were scheduled. On July 11, 2023, at 8:53 a.m., the surveyor inquired what the licensee would do if a ULP called in sick or if two ULPs were scheduled to work the overnight shift. Clinical nurse supervisor (CNS)-C stated they would attempt to find a replacement for the call in and fill the vacant spot opening, however if they were unable to, CNS-C stated, "they are ok at two, but if we are already short the protocol is to call the clinical administrator and then the don [director of nursing] would come in if only one aide is scheduled to work." The surveyor inquired if they had any two person assists in the unsecured unit. CNS-C stated they do in the secured unit however not in the unsecured unit. The surveyor inquired what the licensee's policy was for lift assistance after a fall occurred. CNS-C stated a full mechanical lift assist of two staff was required unless the resident was able to get off the floor independently. The surveyor inquired what the ULP would do if there was a fall in the unsecured unit in the overnight hour and only two ULPs were scheduled to work. CNS-C stated, "if it is safe and people are sleeping, they will quickly leave and go back to the memory care or they will call	02070		

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02070	Continued From page 36 911 if they were unable to assist at the time." The licensee's MN AL Direct Care Staffing Policy dated August 12, 2021, indicated in the event that staffing hours were to be reduced, reductions would be based on resident care needs and would be determined on what would minimally impact resident need times. In addition, minimal staffing levels on each unit would be maintained. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02070		
02090 SS=F	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain a dignified dining experience for all of the memory care residents during the breakfast meal period. 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	02090		

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02090	Continued From page 37 of the residents). The findings include: On July 11, 2022, beginning at 7:58 a.m., until 9:20 a.m., the surveyor observed staff serve residents breakfast in the memory care unit day room, which was utilized as the dining area for the breakfast meal. The memory care unit dining room was used for lunch and dinner meals. ULPs served residents breakfast at staggered times as they arrived to the dining area. ULPs continued to assist in getting residents up for breakfast while others were dining. No one ULP was consistently in the dining area throughout the course of breakfast time. On July 11, 2022, during continuous observation from 9:03 a.m. to 9:11 a.m., no ULPs were present in the dining area. There were nine residents seated in the dining area with food still in front of them. On July 11, 2022, at 9:11 a.m., ULP-M came into the dining area with a cart and began removing plates from the tables. R15 was seated in dining area with plate of scrambled eggs, sausage, and bacon in front of her from approximately 8:30 a.m., until after 9:20 a.m. During this time, the surveyor observed ULP-N and ULP-M stop by R15's chair on separate occasions, each stood next to R15 and assisted with one bite of food. On July 11, 2023, at 9:18 a.m., ULP-M stood next to R15 and assisted with two more bites of food. ULP-M left R15's plate in front of her and left the dining area at 9:20 a.m. The surveyor left the dining area with ULP-M.	02090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30236	A. BUILDING: _____ B. WING _____	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF PLYMOUTH	16205 36TH AVENUE NORTH PLYMOUTH, MN 55446

(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
02090	Continued From page 38 On July 12, 2023, at 11:26 a.m., CNS-C stated the ULP identified as float MC2 on the daily schedule is assigned to the dining area for breakfast. CNS-C indicated that ULP is designated to assist residents that need feeding assistance and was expected to remain in the dining area from the time the first resident arrives until the time the last resident leaves the dining area. On July 12, 2023, at 3:49 p.m., CNS-C indicated through email correspondence, there were two residents on the secured unit that required total assistance with feeding. One of the residents CNS-C identified was R15. The licensee's Dining Room Protocol Policy dated January 2013, indicated after residents are served, the ULP should proceed to assigned table to provide eating assistance. In addition, the ULP should initiate friendly conversation with residents at the table. The policy sequence indicates clearing place settings to occur after resident's have left the dining area. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02090		

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

Type: Full
Date: *07/11/23*
Time: 12:00:00
Report: 1025231161

Food and Beverage Establishment Inspection Report

Location:
Summerwood Of Plymouth
16205 36th Avenue North
Plymouth, MN55446
Hennepin County, 27

Establishment Info:
ID #: 0039301
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7633297452
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

"Sink & Surface" DDBSA: = OK at Degrees Fahrenheit
Location: Higher end of scale
Violation Issued: No

Hot Water: = at 166 Degrees Fahrenheit
Location: Dish machine 20 PSI
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Soup
Temperature: 182 Degrees Fahrenheit - Location: Heat and serve
Violation Issued: No

Process/Item: Tomato, sliced
Temperature: 41 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Process/Item: Melon
Temperature: 41 Degrees Fahrenheit - Location: Upright cooler
Violation Issued: No

Process/Item: Melon
Temperature: 38 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Deli meat
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Type: Full
Date: *07/11/23*
Time: 12:00:00
Report: 1025231161
Summerwood Of Plymouth

Food and Beverage Establishment Inspection Report

Process/Item: Sausage
Temperature: 48 Degrees Fahrenheit - Location: Far prep cooler, cooling from breakfast reported ~3 hrs
Violation Issued: No

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

Discussed dish machine operation and testing, for log, suggest Wash / Rinse / Contact column (adding one for recording the contact temperature when tested with the "puck" thermometer)

Calibrated/tested TMDs in kitchen in ice water w/inspector TMD, +/- 2 deg F OK

Mop sink: Provide a backflow prevention device (ASSE 1011 or 1052) for the faucet (MN 4717)

Discussed raw animal product and highly susceptible populations; when hard shell eggs are subbed out by distributor (raw vs Pasteurized), use for baking, hard-boiling, or fully cooked, do not use for sunny-side up/undercooked eggs or batch scrambled eggs (Pasteurized carton product available).

Please search "MDH Highly Susceptible Populations"

Sanitizer: Sink and Surface product with test kit available. Reported the peroxide-based disinfectant in mop area no longer used; suggest returning to distributor for proper disposal.

Discussed employee health and hygiene (Employee Absence Tracking and illness discussion; illness tracking just to be accessible), disposables for quarantine and food given to aid staff, food temperatures for cooking, holding, cooling, product source, Arbor service (plated meals held in electric hotbox for service, beverage area in the kitchen). Prepackaged candy bars and snacks for sale in retail area.

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 1025231161 of 07/11/23.

Certified Food Protection Manager: Anthony Donato

Certification Number: FM101024 Expires: 10/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____

Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231161

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/11/23
Time In 12:00:00
Time Out

Summerwood Of Plymouth	Address: 16205 36th Avenue North	City/State: Plymouth, MN	Zip Code: 55446	Telephone: 7633297452
License/Permit #: 0039301	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) Tony Poratto **Date:** 07/11/23

Inspector (Signature) Gary Kirsch