

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 27, 2022

Administrator
Madison Avenue Apartments
700 North Madison Street
Minneota, MN 56264

RE: Project Number SL30459015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 4, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation

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that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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 <a href="mailto:em

Please address your cover letter for general reconsideration requests to:

Reconsideration Unit

Health Regulation Division

Minnesota Department of Health

P.O. Box 64970

85 East Seventh Place

St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:

Reconsideration Unit

Health Regulation Division

Minnesota Department of Health

P.O. Box 64970

85 East Seventh Place

St. Paul, MN 55164-0970

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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,

Casey DeVries, Supervisor Health Regulation Division State Evaluation Team 85 East Seventh Place, Suite 220 P.O. Box 3879

Carry White

St. Paul, MN 55101-3879

Email: casey.devries@state.mn.us

Phone: 651-201-5917 Fax: 651-215-6894

HHH

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE : COMPI	
			A. BUILDING.	· 		
		30459	B. WING		05/04/2022	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADISO	N AVENUE APARTME	NTS	'H MADISON A, MN 5626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 000	Initial Comments		0 000			
	In accordance with 144G.08 to 144G.9 issued pursuant to Determination of wirequires compliance provided at the Star When Minnesota Sfailure to comply wired with the Star When Minnesota Sfailure to Comply wired with the Star When Minnesota Star Star Star Star Star Star Star St	PROVIDER LICENSING DER(S) Minnesota Statutes, section 5, these correction orders are a survey. hether violations are corrected e with all requirements tute number indicated below. tatute contains several items, th any of the items will be compliance.		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living License Providers. The assitag number appears in the far-left entitled "ID Prefix Tag." The state number and the corresponding test state Statute out of compliance is the "Summary Statement of Defic column. This column also include findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Contract PLEASE DISREGARD THE HEARTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TOUR SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA STATUTES. The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 1440 subd. 1, 2, and 3.	oftware. to sted igned column Statute kt of the listed in iencies" is the ne state This as eyors' rrection. DING OF THIS O DN FOR FATE d for scope	
0 480 SS=F	144G.41 Subd 1 (1 requirements	3) (i) (B) Minimum	0 480			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30459	B. WING		05/0	4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	, , , , ,	
MADISO	N AVENUE APARTME	NTS	'H MADISON A, MN 5626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 480	Continued From pa	ge 1	0 480			
	following services to (i) at least three nut available seven day recommended dieta States Department guidelines, including fresh vegetables. T (B) food must be pr	ritious meals daily with snacks as per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and				
	by: Based on observati review, the licensee prepared and serve Food Code. This practice resulte violation that did no safety but had the p resident's health or widespread scope (or represent a syste or has the potential the residents). The findings include Please refer to the i and Beverage Estal dated May 5, 2022, Food Code deficien	included document titled, Food blishment Inspection Report for the specific Minnesota				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		30459	B. WING		05/0	4/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADISO	N AVENUE APARTME	NTS	TH MADISON A, MN 5626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 510	Continued From pa	ge 2	0 510			
0 510 SS=E	144G.41 Subd. 3 Ir	fection control program	0 510			
55=E	maintain an infection complies with accenursing standards of (b) The facility's infectonsistent with curricular national Centers for Prevention (CDC) of control in long-term applicable, for infectors assisted living facility (c) The facility must compliance with this MN Requirements by: Based on observation review, the licensed control standards of for two of five unlied ULP-H) during proving medication administration that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number of rethan a limited number.	ection control program must be tent guidelines from the r Disease Control and or infection prevention and care facilities and, as ection prevention and control in ties. It maintain written evidence of subdivision. The tent is not met as evidenced and the failed to ensure infection or hand washing were followed ensed personnel (ULP)-G and rision of personal cares and extration. The tent is not met as evidenced and the failed to ensure infection or hand washing were followed ensed personnel (ULP)-G and rision of personal cares and extration. The tent is not met as evidenced and the failed to ensure infection or hand washing were followed ensed personnel (ULP)-G and rision of personal cares and extration. The tent is not met as evidenced and the failed to ensure infection (a the failed to have harmed a safety, but was not likely to by, impairment, or death), and tern scope (when more than a failed that are affected, more or of staff are involved, or the red repeatedly; but is not ve).				
	On May 3, 2022, at	approximately 6:21 a.m., the				

Minnesota Department of Health

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WIIIIII	na Department of Tie	aitii				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		30459	B. WING		05/0	4/2022
		00400			00/0	77/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADISO	N AVENUE APARTME	NTS 700 NORT	TH MADISON	I STREET		
MADIOO	IT AVEITOE AT ARTIME	MINNEOT	A, MN 5626	4		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIALE	DATE
				,		
0 510	Continued From pa	ge 3	0 510			ļ
	surveyor observed	unlicensed personnel (ULP)-G				
	and ULP-H begin their final rounds of resident checks and cares for the night shift. ULP-H and					
	ULP-G each donned a pair of gloves and entered R3's room where they both provided incontinence					
		gloves and then exited the				
		nsing hands, ULP-G and				
		ew pair of gloves and entered				
		oth ULP's repositioned R2 and				
		d a medication to R2. ULP-G				
	and ULP-H removed their gloves, exited R2's					
		or another residents room.				
		omplete any hand hygiene but				
		r of gloves before entering				
		s in R6's room. There, ULP-H				
		cations to R6. ULP-G and				
		oves and exited R6's room;				
		ved hand hygiene after cares				
		n., ULP-G and ULP-H went to				
		n to get a narcotic medication				
		ntered R7's room and each				
		of gloves. ULP-H administered				
		ner medications to R7, while				
		's catheter bag into a				
		the toilet. ULP-G removed her				
		equest of R7, handed the				
	resident a facial tiss	sue. ULP-H then removed her				
	gloves and both ex	ted R7's room and headed to				
		It was there when ULP-H and				
		ed hands, using the available				
		erform hand hygiene.				
	•	, ,				
	At approximately 6:	51 a.m., the surveyor asked				
		about their lack of hand				
	hygiene between re	sidents' cares. ULP-H stated				
		o changing gloves" that she				
		h her hands or use sanitizer				
		nts. ULP-H acknowledged her				
		ng during rounds. ULP-G				
		emember" on first rounds, but				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30459	B. WING		05/0	4/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MADISO	N AVENUE APARTME	NTS	TH MADISON A, MN 5626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 510	between residents, ULP-G and ULP-H training on infection ULP-G's and ULP-h indicated having su competency on infewashing, dated Dec On May 4, 2022, at registered nurse (R were for staff to wa providing resident of visibly soiled or dirty RN-B said following could be use and sliceansing of hands they were constantly and acknowledged bad habits" and it we catch them. The Licensee's Infepolicy dated August washing will be performed and the provident of the policy dated August washing will be performed and the provident of the provident of the provident of the policy dated August washing will be performed and the provident of the	I be washing hands, definitely even if wearing gloves. each stated they received a control and hand washing. I's employee records ccessfully completed a ection control and hand cember 18, 2021. approximately 3:56 p.m.,	0 510			
0 780 SS=F	physical environme		0 780			
		iving facility must comply with in Minnesota Rules, chapter				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30459	B. WING		05/	04/2022
	PROVIDER OR SUPPLIER N AVENUE APARTME	NTS 700 NOR	DRESS, CITY, S TH MADISON TA, MN 5626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 780	7511, and: (1) for dwellings or the State Fire Code (i) provide smooth for sleeping purpos (ii) provide smooth separate sleeping and bedrooms; (iii) provide smooth separate sleeping and bedrooms; (iii) provide smooth separate sleeping and (iv) where more required within an insleeping unit, interest that actuation of on the individual dwelliful operate; and (v) ensure the smoke alarms comexcept that newly in existing buildings must by: Based on observatificated provide smooth for sleeping purposhad the ability to aff. This practice resultativiolation that did no safety but had the president's health or cause serious injury was issued at a wide problems are pervaluation.	sleeping units, as defined in an expected process. Soke alarms in each room used es; oke alarms outside each area in the immediate vicinity anoke alarms on each story ait, including basements, but spaces and unoccupied attics; the than one smoke alarm is andividual dwelling unit or connect all smoke alarms so the alarm causes all alarms in any unit or sleeping unit to appropriately power supply for existing plies with the State Fire Code, attroduced smoke alarms in any be battery operated; then is not met as evidenced on and interview, the licensee are alarms in each room used es. This deficient condition fect all staff and residents. The din a level two violation (and tharm a resident's health or potential to have harmed a safety, but was not likely to any impairment, or death), and despread scope (when sive or represent a systemic coted or has potential to affect.	0 780			

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STATE FORM 6899 MGWL11 If continuation sheet 6 of 19

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00450		 		4/2225
		30459	B. WING		05/0	4/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADISO	N AVENUE APARTME	NTS	'H MADISON A, MN 5626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 780	Maintenance (DM)-(MA)-K, the survey apartment had a so to central fire alarm but did not have a salarm system device alarm in the sleepir DM-J and MA-K ve the time of discover sleeping rooms in the assisted living condition.		0 780			
0 810 SS=F	physical environments (b) Each assisted I maintain fire safety plans shall include (1) location and norooms; (2) employee active a fire or similar emecal (3) fire protection residents; and (4) procedures for evacuation, or relocation or unusual resident evacuation. (c) Employees of assisted I maintain the safety and I maintai	iving facility shall develop and and evacuation plans. The but are not limited to: umber of resident sleeping ons to be taken in the event of	0 810			

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NAME OF PROVIDER OR SUPPLIER MADISON AVENUE APARTMENTS B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
MADISON AVENUE APARTMENTS 700 NORTH MADISON STREET			30459	B. WING		05/0	04/2022
MINNEOTA, MN 56264			NTS 700 NORT	TH MADISON	STREET		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETE DATE
plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This 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:	0 810	plans upon hiring a thereafter. (d) Fire safety and readily available at (e) Residents who a their own evacuation proper actions to tainclude movement, training shall be maleast once per year (f) Evacuation drills twice per year per sevacuation drill ever the residents is not activation is not required in the following provides a failed to devacuation plan with provide required en on fire safety and econduct required en on fire safety and econduct required expotential to affect a This practice result violation that did not safety but had the president 's health of cause serious injury was issued at a wide problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure that has affer a large portion or all the following problems are pervafailure th	evacuation plans shall be all times within the facility. are capable of assisting in an shall be trained on the ke in the event of a fire to evacuation, or relocation. The ide available to residents at are required for employees shift with at least one ry other month. Evacuation of required. Fire alarm system quired to initiate the evacuation ent is not met as evidenced and record review, the evelop a fire safety and he required elements, failed to apply a plant of a level two violation (and tharm a resident's health or cotential to have harmed a residety, but was not likely to y, impairment, or death), and lespread scope (when isive or represent a systemic cted or has potential to affect	0 810			

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		30459	B. WING		05/	04/2022
	PROVIDER OR SUPPLIER	NTS 700 NORT	DRESS, CITY, S TH MADISON (A, MN 5626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
0 810	Licensed Assisted I Director of Mainten person (MA)-K on the plan, fire safety and evacuation drills for Record review of the indicated that the licensed procedures at lacked these provisional revacuation of the indicated that the findicated that the licensed from the event of an experiment of the show where the planesidents to this or unique or unusual revacuate. Record review of an indicated that the licensed from the person or indicated that the licensed from the person of	proximately 9:40 a.m. with Living Director (LALD)-A, ance (DM)-J and maintenance he fire safety and evacuation devacuation training, and the facility. The available documentation censee did not have fire responses and evacuation plan. The facility and evacuation plan. The facility are available documentation plan. The facility are available documentation responses for resident the plan are available documentation are safety and evacuation plan resident needs for the facility and evacuation plan resident needs for the facility and the licensee had an adjacent school for a shelter mergency but was not able to an indicated how to evacuate any other location and any needs of the residents to available documentation censee provided training for tation and annually, not twice tation as required by statute. ALD-A stated that the to provide training at	0 810			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30459	B. WING		05/0	4/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 30/0	
MADISO	N AVENUE APARTME	NTS	TH MADISON A, MN 5626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 810	training to residents evacuation on the pevent of a fire to incorrelocation as requinterview, LALD-As not have any documwas not able to protraining. Record review of the indicated that the lice evacuation drills evacuation drills evacuation drills avacuation dril	ge 9 s who can assist in their own proper actions to take in the clude movement, evacuation, uired by statute. During stated that the licensee does nented resident training and vide a policy on resident e available documentation censee did not conduct ery other month as required by rview, DM-J stated that we any documentation of ailable for review at the time of				
0 940 SS=C	(21) days. 144G.50 Subd. 2 C (5) a description of medical assistance and section 256B.4 program under char (i) whether the facili commissioner of hucustomized living seassistance waivers; (ii) whether the facili provide housing supsubdivision 2, parage (iii) whether there is people residing at the customized living season, the limit must be	ontract information the facility's policies related to waivers under chapter 256S 9 and the housing support pter 256I, including: ty is enrolled with the iman services to provide ervices under medical lity has an agreement to opport under section 256I.04, graph (b); a limit on the number of the facility who can receive ervices or participate in the ogram at any point in time. If	0 940			

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		30459	B. WING		05/0	4/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADISO	N AVENUE APARTME	NTS	H MADISON			
		MINNEOT	A, MN 5626			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
0 940	Continued From pa	ge 10	0 940			
	payment under med housing support pro time that private par (v) a statement that provide payment for the cost of rent; (vi) a statement that assistance with remprogram; and (vii) a description of people who are elig waivers but who are through the housing (6) the contact infor care consulting serve 256B.0911; and (7) the toll-free photon Adult Abuse Report	medical assistance waivers r services, but do not cover t residents may be eligible for t through the housing support the rent requirements for ible for medical assistance e not eligible for assistance g support program; mation to obtain long-term vices under section the number for the Minnesota ing Center.				
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R2, R3 and R4) with records reviewed. This had the potential to affect all 16 current residents of the 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:					

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30459	B. WING		05/0	4/2022
	PROVIDER OR SUPPLIER N AVENUE APARTME	NTS 700 NOR	TH MADISON			
IIIABIOO	ITATENOE AI ARTIME	MINNEOT	A, MN 5626	4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 940	Continued From pa	ge 11	0 940			
	R2's Resident Agre signed dated Decer	ement for Assisted Living was mber 16, 2021.				
	R3's Resident Agreement for Assisted Living was signed dated December 3, 2021.					
	R4's Resident Agreement for Assisted Living was signed dated August 6, 2021.					
	R2's, R3's and R4's Resident Agreement for Assisted Living contracts lacked the following required content: -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required.					
	licensed assisted livacknowledged the	approximately 2:57 p.m., ving director (LALD)-A missing content from the they would have to have "the e changes.				
	No further informati	ion was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-One				
0 970 SS=F	144.50 Subd. 5 Wa	ivers of liability prohibited	0 970			
1- 7	liability for the healt property of a reside include any provision should know to be of unenforceable under include any provision	not include a waiver of facility h and safety or personal ent. The contract must not on that the facility knows or deceptive, unlawful, or er state or federal law, nor on that requires or implies a care or responsibility than is				

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	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0 970 Continued From page 12 required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	, ,	E CONSTRUCTION	(X3) DATE S COMPL		
		20450	B. WING		05/0	4/2022
NAME OF				27475 710 0005	05/04	4/2022
NAME OF	PROVIDER OR SUPPLIER		TH MADISON	STATE, ZIP CODE LISTREET		
MADISO	N AVENUE APARTME	-NTS	A, MN 5626			
PRÉFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 70 Continued From page 12		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 970	Continued From pa	age 12	0 970			
	required by law.					
	by: Based on interview licensee failed to e contract did not inc facility's liability for property of a reside affect all residents. This practice result violation that did no safety but had the president's health or widespread scope or represent a syst	and record review, the nsure the assisted living slude language waiving the health, safety, or personal ent. This had the potential to ted in a level two violation (a				
	The findings includ	e:				
	2022, at approxima provided a current	ince conference on May 2, ately 12:27 p.m., the licensee copy of the facility's assisted resented to residents in an				
	indicated the reside liability for health, s resident. Page 15, "Indemnification," c agree to indemnify Services Foundatic subsidiaries, affiliat from and against a damages, and liabil with loss of life, per	contract included a clause that ent would waive the facility's safety, or personal property of a Item 25, section A. of the contract indicated: You and hold harmless Living on/Minnesota, LLC, its tes, employees, and agents ny and all claims, actions, ility and expense in connection rsonal injury, or damage to om or out of your use of the				

Minnesota Department of Health

STATE FORM 6899 MGWL11 If continuation sheet 13 of 19

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A 30459 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS A		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	ATE SURVEY DMPLETED		
		30459	B. WING		05/0	4/2022	
		NTS 700 NORT	DRESS, CITY, S TH MADISON TA, MN 5626				
(X4) ID PREFIX TAG	(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
0 970	 O 970 Continued From page 13 premises, or caused wholly or in part by your act or omission. On May 4, 2022, at approximately 2:57 p.m., licensed assisted living director (LALD)-A said she was aware of the surveyor's concern with the indemnification section in their assisted living contract. LALD-A stated they would have to send it back to the lawyers to make the changes, "they wrote it." LALD-A said this was the template for all the assisted living contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days 01470 144G.63 Subd. 2 Content of required orientation 		0 970				
01470 SS=D	(a) The orientation topics: (1) an overview of topics: (2) an introduction applicies and proced of assisted living seperson; (3) handling of emergency services; (4) compliance with maltreatment of vulue 626.557 to the Minroduction (MAARC); (5) the assisted living responsibilities related and protection of the folioness of the complex of the complex of the principles of the complex of the compl	must contain the following his chapter; and review of the facility's lures related to the provision ervices by the individual staff ergencies and use of s; and reporting of the nerable adults under section nesota Adult Abuse Reporting ng bill of rights and staff ted to ensuring the exercise	01470				

Minnesota Department of Health

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MILLIFOC	na Department of the	ailii	_				
	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30459 OF PROVIDER OR SUPPLIER SON AVENUE APARTMENTS D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (A) Continued From page 14 (7) handling of residents' complaints, reporting or complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providin services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN		A. BUILDING:		COMP	LETED		
	TEMENT OF DEFICIENCIES (PLAN OF CORRECTION) (X1) PROVIDER/SUPPLIER (DISON AVENUE APARTMENTS) (SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (Tontinued From page 14) (T) handling of residents' complaints, reporting complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on provid services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technolog that may enhance communication and involvement, including communication strateg assistive listening devices, communication strateg assistive listening devices, communication access in real time, and closed captions. This MN Requirement is not met as evidence by:		B. WING		05/0	4/2022	
		30433			03/0	4/2022	
NAME OF PROVIDER OR SUPPLIER MADISON AVENUE APARTMENTS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 01470 Continued From page 14 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of			DRESS, CITY, S	STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER MADISON AVENUE APARTMENTS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O1470 Continued From page 14 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must		TH MADISON	I STREET				
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TAG		SC IDENTIFYING INFORMATION)	TAG		PRIATE	DATE	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30459 STREET ADDRESS, CITY, STATE. 700 NORTH MADISON STRIMINNEOTA, MN 56264 (STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) In page 14 residents' complaints, reporting of dishere to report complaints, nation on the Office of or Long-Term Care, Office of or Long-Term Care, Office of or Mental Health and Disabilities, Managed Care the Department of Human hy-managed care advocates, or advocacy services; and the types of assisted living inployee will be providing and the ry of licensure. The the Department of Human type of licensure. The the Department of Human type of licensure. The the Department of Human type of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living inployee will be providing and the ry of licensure. The types of assisted living into the ry of licensure and the ry of licensure. The types of assisted living into the ry of licensure and the ry of licensure. The types of assisted will be reported to the ry of licensure and the ry of licensure. The types of assisted will be reported to the ry of licensure. The types of assisted will be reported to the ry of licensure. The types of assisted will be reported to the ry of licensure. The types of assisted will be reported to the ry of li	DEFICIENCY)				
01470	AMADISON AVENUE APARTMENTS MADISON AVENUE APARTMENTS MADISON AVENUE APARTMENTS MADISON AVENUE APARTMENTS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O1470 Continued From page 14 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication ard involvement, including communication strategies assistive listening devices, hearing aids, visual and tactile alerting devices, communication						
	-	DORRECTION DESTIFICATION NUMBER: A BUILDING DESTIFICATION NUMBER: A BUILDING DESTIPICATION NUMBER: A BUILDING DESTIPICATION NUMBER: D					
					PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE		
			STREET ADDRESS, CITY, STATE, ZIP CODE 700 NORTH MADISON STREET MINNEOTA, MN 56264 ES DID PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE 01470 eporting of aints, lealth 2 Office of ce of Care man at the second of the se				
				JILDING: COMPLETED JING 05/04/202 S, CITY, STATE, ZIP CODE ADISON STREET J 56264 JD PROVIDER'S PLAN OF CORRECTION (X) (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) COMPLETED OSCIONAL COMPLETED O			
			STREET ADDRESS, CITY. STATE, ZIP CODE TOO NORTH MADISON STREET MINNEOTA, MN 56264 TOF DEFICIENCIES BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE O1470 Complaints, reporting of report complaints, ne Office of the Balth and s., Managed Care thment of Human d care advocates, or ervices; and if assisted living lbe providing and the sure. Sin paragraph (a), ain training on providing hearing loss. Any rovided under this quality and research training, and must more of the following related hearing, to untreated such as increased lls, hospitalizations, or greated and must more of the tonloogy microation and mumunication strategies, it, hearing aids, visual s, communication losed captions. not met as evidenced ecord review, the				
					COMPLETED 05/04/2022 TOTAL COMPLETED 05/04/2022 TOTAL COMPLETE COMPLETE PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE COMPLETE DATE)		
	including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following						
				G: COMPLETED 05/04/2022 7, STATE, ZIP CODE DN STREET 264 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE			
		one or more of the following					
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	access in real time,	and closed captions.					
	This MN Doguiron	ant is not mot as avidanced					
	· ·	ent is not met as evidenced					
		and record review the					

STATE FORM 6899 If continuation sheet 15 of 19 MGWL11

STATEMEN	MADISON AVENUE APARTMENTS 700 NOR MINNEC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		30459	B. WING		05/0	4/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
MADISON AVENUE APARTMENTS 700 NORTH MINNEOTA, (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)							
(V4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CORRECTION	ON.	(Y5)	
PRÉFIX	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30459 THE OF PROVIDER OR SUPPLIER DISON AVENUE APARTMENTS TOO NO MINNE A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) THE ORIGINAL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 15 orientation to the assisted living facility licensing requirements and regulations for one of three employees, (unlicensed personnel (ULP)-H) wemployee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health on 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 2, 2022 at approximately 11:36 a.m., licensed assisted living director (LALD)-A stated she was familiar with the statutes and regulations for assisting living, including employee training. LALD-A verified they provided assisted living services, and had a current license, effective August 1, 2021. ULP-H was hired July 18, 2018, to provide directore care services to the licensee's residents. Training records for ULP-H lacked evidence the employee was oriented to the new assisted living licensing requirements in the following areas: -an overview of 144G statutes; -review of all the provider's policies and procedures related to the provision of assisted	MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE	
01470	AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30459 OF PROVIDER OR SUPPLIER SON AVENUE APARTMENTS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 15 orientation to the assisted living facility licensir requirements and regulations for one of three employees, (unlicensed personnel (ULP)- H) we employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), are was issued at an isolated scope (when one or limited number of residents are affected or one a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 2, 202 at approximately 11:36 a.m., licensed assisted living director (LALD)-A stated she was familia with the statutes and regulations for assisting living, including employee training. LALD-A verified they provided assisted living services, and had a current license, effective August 1, 2021. ULP-H was hired July 18, 2018, to provide director exercises to the licensee's residents. Training records for ULP-H lacked evidence the employee was oriented to the new assisted living services and procedures related to the provision of assisted living services under 144G statutes; -review of all the provider's policies and procedures related to the provision of assisted living services under 144G statutes; -review of types of assisted living services the employee will provide; and	ge 15	01470				
	requirements and reemployees, (unlice	egulations for one of three nsed personnel (ULP)- H) with					
	violation that did no safety but had the p resident's health or cause serious injury was issued at an is limited number of a limited number of	ot harm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death), and colated scope (when one or a esidents are affected or one or staff are involved or the					
	The findings include	e:			O5/04/2022 ION (X5) LD BE COMPLETE		
	at approximately 11 living director (LALI with the statutes an living, including em verified they provide and had a current li	:36 a.m., licensed assisted D)-A stated she was familiar and regulations for assisting ployee training. LALD-A ed assisted living services,					
		•					
	employee was orientlicensing requirements an overview of 1444 review of all the procedures related living services under review of types of a semployee will proving services.	nted to the new assisted living ents in the following areas: IG statutes; ovider's policies and to the provision of assisted er 144G statutes; assisted living services the de; and					

Minnesota Department of Health STATE FORM

	MADISON AVENUE APARTMENTS 700 NORT	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30459	B. WING		05/0	4/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MADISO	N AVENUE APARTME	NTS	A, MN 5626			
PRÉFIX	A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 1470 Continued From page 16		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01470	On May 4, 2022, at assisted living direct were given a packet covered the new or and other topics. LA completed or turned. The licensee's 5.01 Supervisors & Cont 2021, all staff of the supervising direct sorientation to Assist requirements and reassisted living service.	approximately 3:10 p.m., stor (LALD)-A stated the staff t of training to complete that ientation for the new statutes ALD-A verified ULP-H had not d in the assigned training. Orientation of Staff and sent policy, dated August 1, a facility providing and ervices must complete an sed Living facility licensing egulations before providing ces to residents.	01470			
01530 SS=D	(a) All assisted livin following training re (1) supervisors of d least eight hours of specified under par hours of the employ have at least two hor related to dementia employment therea (2) direct-care emp at least eight hours specified under par hours of the employ initial training is corprovide direct care	irect-care staff must have at initial training on topics agraph (b) within 120 working ment start date, and must ours of training on topics care for each 12 months of	01530			

6899

Minnesota Department of Health STATE FORM

STATEMEN	ADISON AVENUE APARTMENTS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O1530 Continued From page 17 eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervis meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30459	B. WING		05/0	4/2022
NAME OF PROVIDER OR SUPPLIER STREET ADD 700 NORT		DRESS, CITY, S	STATE, ZIP CODE			
MADISO	N AVENUE APARTME	NTS	H MADISON			
()(1) ID	SHIMMA DV STA		A, MN 5626	PROVIDER'S PLAN OF CORRECT	ON	(VE)
PRÉFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 eight hours of training on topics related to		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01530	Continued From pa	ge 17	01530			
	eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of three employees, (unlicensed personnel (ULP)- H) received the required amount of dementia-care training as required with employee records reviewed.					
	violation that did no safety but had the president's health or cause serious injury was issued at an is limited number of ralimited number of situation has occurr. The findings include The licensee providiving license. ULP-H was hired Jucare services to the On May 3, 2022, be	ot harm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally). The electric services under an assisted of the electric services residents.				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND BLAN OF CORRECTION \ \ \ \ IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:		DATE SURVEY COMPLETED			
			7t. Boilebiito.				
		30459	B. WING		05/04/2022		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MADISO	N AVENUE APARTME	NTS	TH MADISON A, MN 5626				
(X4) ID PREFIX TAG	ISON AVENUE APARTMENTS MINNEOT ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
01530	Continued From pa	ige 18	01530				
		nerous residents in the					
		anscript lacked evidence of equired 8.0 hours of dementia					
	assisted living direct were given a packed covered the new or and other topics. La or direct care employeementia training.	approximately 3:10 p.m., ctor (LALD)-A stated the staff et of training to complete that rientation for the new statutes ALD-A stated unlicensed staff byees needed eight hours of LALD-A verified ULP-H had not d in the assigned training.					
	dated August 1, 20: licensee are require training at the time The policy indicated complete eight (8)	B Dementia Training policy, 22, indicated all staff of the ed to complete dementia of hire and annually thereafter. d direct care employees will hours of initial training within inployment start date.					
	No further informat	ion was provided.					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one					

6899

Minnesota Department of Health STATE FORM



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

Type: Full
Date: 05/05/22
Time: 12:00:56
Report: 1020221055

Food and Beverage Establishment Inspection Report

Page 1

Locat	

Madison Avenue Apartments 700 North Madison Street Minneota, MN56264 Lyon County, 42

License Categories:

Expires on: //

Establishment Info:

ID#: 0037738

Risk:

Announced Inspection: No

Operator:

Phone #: 5078725300

ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

MOLD GROWTH ON THE BAFFLE OF THE ICE MACHINE; CLEAN.

Comply By: 05/09/22

6-100 Physical Facility Construction Materials

6-101.11A3

MN Rule 4626.1325A3 Provide nonabsorbent floor, wall, and ceiling surfaces for food preparation areas, walk-in refrigerators, warewashing areas, toilet rooms, all servicing areas, and areas subject to flushing or spray cleaning methods.

ACOUSTIC TILES USED IN AREAS WHERE FOOD PREPARATION AND DISHWASHING OCCUR; REPLACE WITH SMOOTH VINYL TILES.

Comply By: 12/31/22

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit

Location: DISHWASHER Violation Issued: No

Page 2

Type: Full
Date: 05/05/22
Time: 12:00:56
Report: 1020221055

Food and Beverage Establishment Inspection Report

Madison Avenue Apartments

Food and Equipment Temperatures

Process/Item: Hot Holding

Temperature: 163 Degrees Fahrenheit - Location: BAKED POTATO - STEAM WELL

Violation Issued: No

Process/Item: Hot Holding

Temperature: 172 Degrees Fahrenheit - Location: HAMBURGER - STEAM WELL

Violation Issued: No

Process/Item: Hot Holding

Temperature: 192 Degrees Fahrenheit - Location: CORN - STEAM WELL

Violation Issued: No

Process/Item: Hot Holding

Temperature: 176 Degrees Fahrenheit - Location: TACO MEAT - STEAM WELL

Violation Issued: No

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: TURKEY - UPRIGHT COOLER

Violation Issued: No

Process/Item: Cold Holding

Temperature: 35 Degrees Fahrenheit - Location: SLICED TURKEY - WALK-IN COOLER

Violation Issued: No

Process/Item: Cold Holding

Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - WALK-IN FREEZER

Violation Issued: No

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

GENERAL COMMENTS:

DISCUSSED COVID-19 AND EMPLOYEE ILLNESS POLICIES AND PROCEDURES.

DISCUSSED COOLING AND RE-HEATING PROCEDURES.

Type: Full Date: 05/05/

Time:

05/05/22 12:00:56

22 56

Food and Beverage Establishment Inspection Report

Page 3

Report: 1020221055 Madison Avenue Apartments

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 1020221055 of 05/05/22.

Certified Food Protection	n Manager <u>Jody B</u>	Baloun	
Certification Number:	FM108510	Expires:	11/22/24

Inspection report reviewed with person in charge and emailed.

Signed: Reportemailed

Establishment Representative

Signed:

Ashley B

651-201-4500

Report #: 10202210	055	Food Establis	hn	ner	nt li	ารต	ection	n Repo	rt				
100	Minnesota Depar			\Box				Categories O		1	Date 0	5/05/2	
Food, Pool, & Lodging Services					No. of Repeat RF/PHI Categories Out					0	Time In 12		
DEPARTMENT	P.O. Box 64975 Saint Paul. MN 5	5164-0975				Legal Authority MN Rules Chapter 4626					Time Out		
OF HEALTH Madison Avenue Apa		Address				y/Stat	е	ty milit realise c	Zip Code		phone		
License/Permit #		700 North Madison Street Permit Holder				nneota	of Inspection	ın.	56264 Est Type	5078	8725300 Risk Catego	.	
0037738		Permit Holder			Fu	•	oi inspectio	711	Est Type		Risk Catego	ıy	
	FOODE	BORNE ILLNESS RISK FAC	TOR	S A	ND F	UBL	IC HEALT	TH INTERV	ENTIONS				
Circle des	ignated compliance sta	tus (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 com	pliance N/O= not observed	N	/A= no	ot applic	able	СО	S=corrected on-	site during inspection		R= repeat vi	olation	1
Compliance S	tatus		cos	R		Com	pliance Sta	atus				cc	os F
		Surpervision						Time/Ten	perature Control	for Sa	fety		
1 (IN) OUT		le; duties & oversight			18	IN O	UT N/A(N/O	Proper cooki	ng time & tempera	ture			
2 (IN)OUT N/A	·	tection manager, duties	Ш		19		UT N/A(N/O	<u> </u>	ting procedures fo		olding		_
		mployee Health	т т		20	_	$\overline{}$		ig time & temperat				_
(IN) OUT	1 -	edge,responsibilities&reporting		_	21	IN)0	UT N/A N/O	Proper hot ho	olding temperature	s			\perp
I (IN) OUT	· · · · · · · · · · · · · · · · · · ·	orting, restriction & exclusion		_		\sim	UT N/A		olding temperatur				
N) OUT	events	sponding to vomiting & diarrheal			23(IN)0	UT N/A N/O	Proper date r	marking & dispositi	on			
		Hygenic Practices			24	IN O	UT(N/A) N/O	Time as a pu	blic health control:	proced	dures & records		_ [
(IN) OUT N/C	Proper eating, tas	sting, drinking, or tobacco use						Con	sumer Advisory				
		n eyes, nose, & mouth			25	IN C	DUT(N/A)		dvisory provided fo		ndercooked foo	d	I
	Preventing C	Contamination by Hands					$\widehat{}$	Highly St	sceptible Popula	tions			
8(IN) OUT N/	Hands clean & pr	operly washed			26	IN C	OUT(N/A)		oods used; prohib				$oldsymbol{oldsymbol{oldsymbol{oldsymbol{I}}}$
9 IN OUT N/A N/O		ntact with RTE foods or pre-approved						Food and Co	olor Additives an	d Toxic	Substances		
	anomate pprocess	lure properly followed	\vdash	_	27	$\overline{}$	UT(N/A)		es: approved & pro				4
10(IN)OUT	<u> </u>	ashing sinks supplied/accessible proved Source	\sqcup		28(IN)O	UT		nces properly iden				ᆚ
(IN) OUT		om approved source	1		00	111 0	117 11/0		with Approved F				_
2 IN OUT N/A(N/C		proper temperature			29	IN O	UT(N/A)	Compliance	with variance/spec	alized	process/HACC		\perp
\rightarrow	4	· · · · · · · · · · · · · · · · · · ·											
I3(IN) OUT	+	dition, safe, & unadulterated	\vdash	_									
14 IN OUT(N/A) N/C	parasite destruction	available; shellstock tags, on			Diel	facto	re (DE) are in	mpropor practic	ces or proceedures	idontit	find as the mos		
	Protection fr	om Contamination			prev	alent	contributing fa	actors of foodb	orne illness or inju	ry. Pub	lic Health Inte	rventi	ions
15 IN) OUT N/A N/	O Food separated a				(PH) are	control measu	ures to prevent	foodborne illness	or injur	y.		
16 IN (OUT)N/A	· ·	aces: cleaned & sanitized											_
		of returned, previously served,	\vdash	\dashv									
I7(IN) OUT	reconditioned, & u												
•		GOO	D R	ETA	IL PI	RAC	TICES						
God	od Retail Practices	are preventative measures to control						s, and physica	l objects into foods	S.			
Mark "X" in box if n	numbered item is no	t in compliance Mark "X"	' in ap	propi	riate bo	ox for (COS and/or F	COS=	corrected on-site dur	ng inspe	ection R= repe	at viola	atior
			cos	R								cos	الخ
	Safe Food ar	nd Water					1	-	er Use of Utensils				
30 IN OUT (N/A) Pasteurized egg	gs used where required			43		In-use uten	sils: properly s	tored				퇶
31 Water &	ice obtained from a	n approved source			44		Utensils, ed	quipment & line	ens: properly store	d, dried	l, & handled		\perp
32 IN OUT(N/A)	Variance obtaine	d for specialized processing methods		\neg	45		Single-use/	single service	articles: properly s	tored 8	used		
114 00 1(14/A)		· · · · · · · · · · · · · · · · · · ·	Ш		46		Gloves use	d properly					
	Food Temperat							Utensil E	quipment and Ve	nding			
	poling methods used ure control	l; adequate equipment for			47			n-food contact sconstructed, &	surfaces cleanable used	, prope	erly		
34 IN OUT N/A	N/O Plant food pro	operly cooked for hot holding			48		Warewashi	ng facilities: in:	stalled, maintained	l, & use	ed; test strips		+
35 (IN) OUT N/A	N/O Approved that	wing methods used			49		Non-food c	ontact surface:	s clean				T
36 Thermom	neters provided & ac	curate						Ph	ysical Facilities				
	Food Ident				50		Hot & cold	water available	e; adequate pressu	re			Т
37 Food pro	perly labled; original	container			51		Plumbing ir	nstalled; prope	r backflow devices				T
	Prevention of Fo	ood Contamination			52		Sewage &	waste water nr	operly disposed				\top
38 Insects, re	odents, & animals no	ot present			53			<u> </u>	onstructed, supplie	ed & cle	eaned		+
39 Contamin	ation prevented duri	ing food prep, storage & display							y disposed; facilitie				+
	cleanliness		\top		54	~			•				+
	oths: properly used &	& stored	\dashv	-	55	Х	-		I, maintained, & cle				+
	fruits & vegetables		+	-	56				hting; designated a	areas u	sed		+
vvasimiy	a vogotables				57		· ·	with MCIAA					+
Food Recalls:				_	58		Compliance	e with licensing	3 & plan review				\perp
Person in Charge (S	Signature) Repo	rtemailed							Date: 05/16/22				
		<u> </u>											—
Inspector (Signature	and.	2 RU											