Electronically Delivered

March 20, 2024

Licensee
Scenic Hills Alternative Care
2519 County Road I
Mounds View, MN 55112

RE: Project Number(s) SL27182015

Dear Licensee:

On March 19, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 2, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Electronically Delivered

February 26, 2024

Licensee
Scenic Hills Alternative Care
2519 County Road I
Mounds View, MN 55112

RE: Project Number(s) SL27182015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 2, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
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. 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 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27182	A. BUILDING: _____ B. WING _____	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2519 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER 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: SL#27182 On January 29, 2024, through February 2, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 5 active residents; 5 receiving services under the Assisted Living license. An immediate correction order for tag identification number 0470 was issued on January 31, 2024. The immediacy of the order was removed on February 1, 2024.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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 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 evaluators' 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 SUBDIVISION 1-3.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sufficient staffing to meet the reasonably foreseen unscheduled needs of one of one resident (R2), who required two-person assist. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 470		

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0 470	Continued From page 2 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's health facility identification (HFID) 27182 was located at 2519 County Road I, Mounds View, Minnesota (MN) 55112 and was attached to 2517 County Road I, Mounds View, MN 55112 with HFID 27183 by a shared wall as a side- by-side twin home. The licensees shared the same owner. During the entrance conference on January 29, 2024, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-B stated one unlicensed personnel (ULP) and one licensed practical nurse (LPN) were scheduled from 8:00 a.m. to 4:00 p.m., one ULP was scheduled from 4:00 p.m. to 12:00 a.m., and one ULP was scheduled from 12:00 a.m. to 8:00 a.m. On January 31, 2024, at 10:35 a.m., surveyor observed two in-line fire doors located in the separating wall between facility number 1 and facility number 2 on the main floor. R2 was admitted on July 11, 2022. R2's unsigned service plan dated January 29, 2024, indicated R2 required an assist of two people with bed mobility, used an EZ stand (mechanical lift used when a resident can bear some body weight) for all mobility, and required a two-person assist while using the EZ stand.	0 470		

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0 470	Continued From page 3 R2's comprehensive assessment dated December 18, 2023, indicated R2 required complete assist with dressing, bathing, continence care, wheeling, and transferring. The assessment also indicated R2 required two people to assist with transferring per physical therapy (PT) report. The assessment further indicated R2's previous facility (provider) discharged R2 for safety as R2 needs a two person assist and they did not provide that service. The licensee's Staffing Plan undated, indicated one ULP worked the night shift from 12:00 a.m. to 8:00 a.m. The licensee's Shifts Routine document undated, indicated night shift routines: -2:30 a.m. assist R2 to the rest room if needed and check and change; and -5:50 a.m. check on R2 make sure dry, if not then change. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated October 1, 2023, noted the number of unlicensed direct care staff typically scheduled for the night shift was one, and transfers with assist of two staff available was not checked. The licensee's posted schedule dated January 1, 2024, through January 31, 2024, indicated one ULP was assigned to the night shift from 12:00 a.m. to 8:00 a.m. On January 31, 2024, at 10:40 a.m., licensed assisted living director (LALD)-A stated the fire doors allowed staff to access each facility and there was one ULP staffed in each facility for the evening shift and only one ULP covering both	0 470		

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0 470	Continued From page 4 facilities for the night shift, with an on-call program manager as back up staff. LALD-A also stated during the night shift, staff propped open the door to each facility while caring for resident needs. The licensee's Direct Care Staffing policy 3.27 dated August 3, 2023, indicated a minimum of two direct staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct care staff for scheduled reasonably foreseeable and unscheduled needs as reflected in the resident's assessment and service plan. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE An immediate correction order for tag identification number 0470 was issued on January 31, 2024. The immediacy of the order was removed on February 1, 2024.	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.	0 480		

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0 480	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	0 630		

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0 630	Continued From page 6 by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: R2 was admitted on July 11, 2022. R2's IAPP dated December 18, 2023, indicated R2 is at risk to be abused and did not include: - the resident's susceptibility to abuse by another individual, including other vulnerable adults; and - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On January 29, 2024, at 1:30 p.m., clinical nurse supervisor (CNS)-B confirmed R2's IAPP did not address the above noted areas of risk or include statements of specific measures to be taken to minimize risks. CNS-B stated was not aware of the required contents of the IAPP and completed the IAPP based on the questions shown in the Service Plan-IAPP health record. The licensee's Service Plan Implementation and Revision policy 3.19 undated, indicated the plan would include identified risks and plan to address	0 630		

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0 630	Continued From page 7 said risks. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (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 observation and interview, the licensee	0 680		

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0 680	Continued From page 8 failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 29, 2024, at approximately 12:00 p.m., licensed assisted living director (LALD)-A provided a binder and indicated the contents were the licensee's EPP. The licensee's EPP undated, lacked documentation including all the required elements of: -annual review; -missing resident quarterly review; -process for EP collaboration; -development of EP policies/procedures (P/P), based on HVA assessment and communication plan; -subsistence needs for staff and residents; -procedures for tracking staff and residents; -policies and procedures for medical documents and volunteers; -roles under a waiver declared by secretary; -development of communication plan; -methods for sharing information; -LTC family notifications; and -emergency prep testing requirements.	0 680		

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0 680	Continued From page 9 On January 29, 2023, at approximately 3:25 p.m., LALD-A acknowledged the licensee's EPP lacked the above listed required content. The licensee's Disaster and Emergency Preparedness plan undated, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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 physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 10 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 31, 2024, at 1:30 p.m., survey staff toured the facility with unlicensed personnel (ULP)-D. During the facility tour, survey staff observed the following items: It was observed the facility was one of two units in a building that appeared to be constructed as a duplex or two-family dwelling. Each unit were separated by what appeared to be a fire resistance rated wall construction, with two 90-minute rated fire doors (labeled) installed on each side of the fire separation wall. During the tour with ULP-D on January 31, 2024, at 1:30 p.m., it was observed that ULP-D propped open both doors with rubber door wedges to override the closure devices on the door that maintain the fire protection of the opening. During the interview on January 31, 2024, at 1:40 p.m., ULP-D stated the other side is also a licensed assisted living facility which is under the same ownership, and only one staff works for both facilities at night. ULP-D also stated that staff propped the door open with door wedges to go back and forth between the two sides. Survey staff explained that the rubber wedge would prevent the doors from closing properly in the event of a fire. On the main entrance door, it was observed that	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27182	A. BUILDING: _____ B. WING _____	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2519 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 11 the slide latch lock was installed at the top of the door, about 6'-6" above the finish floor. This door was identified as an exit on the evacuation plans posted in the facility. Survey staff explained to ULP-D that the slide latch lock installed at that elevation posed a risk of restricting exiting for residents during an emergency. During the interview with ULP-D on January 31, 2024, at 1:40 p.m., ULP-D stated the facility uses the slide latch lock at night only but confirmed that the slide latch lock can pose a risk of restricting exiting for residents with wheelchairs during an emergency. On the front entrance outside of the main exit door, it was observed that burnt, used cigarettes were being disposed of without a proper disposal container, creating a possible fire hazard. During the interview with ULP-D on January 31, 2024, at 1:40 p.m., ULP-D confirmed the provided cigarette disposal container was broken and creating a possible fire hazard. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27182	A. BUILDING: _____ B. WING _____	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2519 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 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 drill. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27182	A. BUILDING: _____ B. WING _____	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2519 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 30, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. EMERGENCY EVACUATION PLAN Record review of the available documentation indicated that the licensee failed to develop and maintain fire safety and evacuation plans with the required elements. On January 29, 2024, at 11:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following: It was observed that the posted fire safety and evacuation plans were not accurate depictions of the egress route and did not match the current layout of the facility. In the living room, there was a door connected to the side of the townhouse; however, the door and the link were not shown in the posted evacuation plan. The kitchen window was identified as an emergency exit on the posted main-level evacuation plan. During the facility tour, it was observed that the window exceeded the maximum sill height requirement and did not meet the egress window opening requirement.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27182	A. BUILDING: _____ B. WING _____	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2519 COUNTY ROAD I MOUNDS VIEW, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 14 The dining room door to wood deck was identified as an emergency exit on the posted main-level evacuation plan. During the facility tour, it was observed that the raised wood deck was enclosed with rails without any egress stairs to the yard. The FSEP and the posted evacuation plan at all levels did not show the location and number of resident rooms. During the interview January 30, 2024, at 11:00 a.m., LALD-A confirmed the upper-level evacuation plan was not an accurate depiction of the current layout, and the egress route shown in the main level did not match the facility egress procedures and needed to be updated. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on January 30, 2024, at 11:00 a.m., LALD-A confirmed that the facility has a fire safety policy for staff but has not developed the necessary fire protection procedures for residents. DRILLS Record review of the available documentation indicated the licensee did not conduct fire drills for employees twice per year per shift as required by statute. Provided documentation indicated that the drills were conducted every other month as required but failed to provide drills for the afternoon and night shifts. Review of the provided documented drills	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27182	A. BUILDING: _____ B. WING _____	02/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2519 COUNTY ROAD I MOUNDS VIEW, MN 55112

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0 810	Continued From page 15 indicated that the licensee had conducted fire drills on 3/16/23 at 2:00 p.m., 5/17/23 at 3:00 p.m., 7/19/23 at 2: 00 p.m., 9/13/23 at 2:00 p.m., 11/18/23 at 3:00 p.m., and 1/8/24 at 2:00 p.m., with no further drills being documented. Provided documentation indicated that the licensee failed to provide two drills for the evening and night shifts. During the interview on January 30, 2024, at 11:00 a.m., LALD-A verified the drills were provided mainly at 2:00 p.m. and 3:00 p.m. for the morning shift and confirmed the licensee failed to provide drills for the afternoon and night shifts. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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

Type: Full
Date: *01/29/24*
Time: 12:30:00
Report: 1025241011

Food and Beverage Establishment Inspection Report

Location:
Scenic Hills Alternative Care
2519 County Road I
Mounds View, MN55112
Ramsey County, 62

Establishment Info:
ID #: 0038315
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7634327795
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.

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
Milk in refrigerator at 43 deg F, maintain cold TCS foods at 41 deg F or below.
Comply By: 01/29/24

4-300 Equipment Numbers and Capacities
4-301.12A ***** Priority 2 *****
MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.
Provide a 3 compartment sink or a dishwasher rated for sanitizing; see additional comments (1/29/24)
Comply By: 03/29/24

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
CFPM expired a few days prior to inspection, CFPM lookup has it expired. If expired, the CFPM course would be retaken. Renew prior to expiration to avoid having to re-test.
Comply By: 01/20/24

4-200 Equipment Design and Construction

4-202.16

MN Rule 4626.0540 Provide non-food contact surfaces that are free of unnecessary ledges, projections and crevices and are designed and constructed to allow easy cleaning.

Cabinet door handles and counter surface painted, paint wearing away. Replace cabinet door handles so they are smooth and easily to clean, and maintain the countertops as a non-food contact surface and plan a replacement (or, remove paint to original).

Comply By: 02/21/24

4-300 Equipment Numbers and Capacities

4-301.12C

MN Rule 4626.0680C Receptacles that substitute for the compartments of a multicompartment sink may be used as alternative manual warewashing equipment if approved.

As a temporary measure until a dishwasher that meets NSF Standard 184 or a 3 compartment sink are provided, substitute a container for Sanitizing using the existing dishwasher to Wash and Rinse.

Comply By: 01/29/24

Food and Equipment Temperatures

Process/Item: Non-TCS
Temperature: 53 Degrees Fahrenheit - Location: Upstairs refrigerator door (pickles)
Violation Issued: No

Process/Item: Milk
Temperature: 43 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

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

Food thermometer available
Quat ammonia tabs available
Reported quat ammonia kit

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher, does not meet the requirements of MN 4626.0506
Facility does not have a 3 compartment sink
Facility does not have a food preparation sink
Facility does not have a stand-alone/dedicated handwashing sink

FACILITY
Kitchen has VCT tile floor, laminate painted countertops, painted wood cabinets, hollow enclosed cabinet bases, Appliances are residential
Replace the cabinet hardware with stainless handles that are completely smooth (without rigids or indents in the back)
Refrigerator/freezer in laundry room

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher).
Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

DISHWASHING - NON ANSI/NSF 184
Dishwasher is not marked with label/data plate indicating it reaches an internal contact temperature necessarily for sanitizing (NSF/ANSI 184: Residential Dishwasher). For information, please search "NSF Residential Dishwashing 184"

As a temporary measure, until a new dishwasher or 3 compartment sink can be installed:
Discussed using the dishwasher to wash and rinse dishes and utensils, and providing a bus tub/other basin for a chemical sanitizing (e.g. chlorine bleach 50-100 PPM or other chemical per label for sanitizing "food contact surfaces", submerge utensils for 1-2 minutes and air dry). Sanitize clean dishes and utensils in a container large enough to submerge the largest utensil. Provide an appropriate sanitizer for "food-contact surfaces" (label will include it as a heading) and an appropriate test kit.

4626.0680 Alternative manual warewashing equipment that meets the requirements in parts 4626.0875 and 4626.0880 may be used when there are special cleaning needs or constraints and its use is approved by the regulatory authority. Alternative manual warewashing equipment may include:
[_] (5) receptacles that substitute for the compartments of a multicompartment sink.
https://www.nsf.org/consumer-resources/articles/dishwasher-certification

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), pest control, quarantine meals

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Chemical label, use, and storage
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page
"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025241011 of 01/29/24.

Certified Food Protection Manager: Watta Kamara

Certification Number: FM105322 Expires: 10/20/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Crystal

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

Report #: 1025241011

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	2	Date	01/29/24
No. of Repeat RF/PHI Categories Out	0	Time In	12:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

Scenic Hills Alternative Care	Address: 2519 County Road I	City/State: Mounds View, MN	Zip Code: 55112	Telephone: 7634327795
License/Permit #: 0038315	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

		Safe Food and Water			COS	R
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				

		Proper Use of Utensils	COS	R
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	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	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) **Date:** 01/29/24

Inspector (Signature) Gary King