Electronically Delivered
January 10, 2023

Licensee
Havenwood Of Richfield
245 West 76th Street
Richfield, MN 55423

RE: Project Number(s) SL33959016

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 27, 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.

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

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

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

The correction order documentation should include the following:

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

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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

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,

Jessica Sellner, RN, Supervisor
Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: jessica.sellner@state.mn.us
Phone: 320-223-7370 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33959	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF RICHFIELD	245 WEST 76TH STREET RICHFIELD, MN 55423

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 33959016 On December 19, 2022, 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 43 residents receiving services under the provider's Provisional Assisted Living with Dementia Care Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all 43 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation	0 480		

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0 480	Continued From page 2 included in the Food and Beverage Establishment Inspection Reports dated December 19, 2022. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.	0 650		

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0 650	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required orientation content for six of six staff members executive director (ED)-A, registered nurse (RN)-B, unlicensed personnel (ULP)-C, ULP-D, ULP-E, and ULP-F, with employee records reviewed. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ED-A was hired on March 14, 2022, under the licensee's assisted living license. ED-A's employee record lacked evidence of orientation to assisted living regulations to include the following components: -Overview of Home Care/Assisted Living statutes -Review of provider's policies and procedures -Reporting maltreatment of vulnerable adults or minors -Home care/Assisted Living bill of rights -Handling of resident/clients' complaints, reporting of complaints, where to report -Consumer advocacy services ED-A's employee file also lacked evidence of 8	0 650		

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0 650	Continued From page 4 hours of initial dementia care training within 120 hours of hire. ED-A's file indicated 6 of the required 8 hours of dementia care training were completed. RN-B was hired on November 21, 2022, under the licensee's assisted living license. RN-B's employee record lacked evidence of orientation to assisted living regulations to include the following components: -Overview of Home Care/Assisted Living statutes -Review of provider's policies and procedures -Handling emergencies and using emergency services -Reporting maltreatment of vulnerable adults or minors -Home care/Assisted Living bill of rights -Handling of resident/clients' complaints, reporting of complaints, where to report -Consumer advocacy services -Review of types of Home Care/Assisted Living services the employee will provide and provider's scope of license -Principles of person-centered planning/service delivery RN-B's employee file also lacked evidence of 8 hours of initial dementia care training within 120 hours of hire. RN-B's file indicated 3 of the required 8 hours of dementia care training were completed. ULP-C was hired on July 25, 2022, under the licensee's assisted living license. ULP-C's employee record lacked evidence of orientation to assisted living regulations to include the following components:	0 650		

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0 650	Continued From page 5 -Overview of Home Care/Assisted Living statutes -Review of provider's policies and procedures -Home care/Assisted Living bill of rights -Handling of resident/clients' complaints, reporting of complaints, where to report -Consumer advocacy services ULP-D was hired on April 20, 2022, under the licensee's assisted living license. ULP-D's employee record lacked evidence of orientation to assisted living regulations to include the following components: -Overview of Home Care/Assisted Living statutes -Review of provider's policies and procedures -Reporting maltreatment of vulnerable adults or minors -Home care/Assisted Living bill of rights -Handling of resident/clients' complaints, reporting of complaints, where to report -Consumer advocacy services -Review of types of Home Care/Assisted Living services the employee will provide and provider's scope of license ULP-D's employee file also lacked evidence of 8 hours of initial dementia care training within 80 hours of hire. ULP-D's file indicated 6.5 of the required 8 hours of dementia care training were completed. ULP-E was hired on August 10, 2022, under the licensee's assisted living license. ULP-E's employee record lacked evidence of orientation to assisted living regulations to include the following components: -Overview of Home Care/Assisted Living statutes -Review of provider's policies and procedures	0 650		

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0 650	Continued From page 6 -Home care/Assisted Living bill of rights -Handling of resident/clients' complaints, reporting of complaints, where to report -Consumer advocacy services ULP-F was hired on February 17, 2022, under the licensee's assisted living license. ULP-F's employee record lacked evidence of orientation to assisted living regulations to include the following components: -Overview of Home Care/Assisted Living statutes -Handling emergencies and using emergency services -Reporting maltreatment of vulnerable adults or minors -Home care/Assisted Living bill of rights -Handling of resident/clients' complaints, reporting of complaints, where to report -Consumer advocacy services -Review of types of Home Care/Assisted Living services the employee will provide and provider's scope of license -Principles of person-centered planning/service delivery ULP-F's employee file also lacked evidence of 8 hours of initial dementia care training within 80 hours of hire. ULP-F's file indicated 2 of the required 8 hours of dementia care training were completed. On December 21, 2022, at 11:00 a.m., executive director (ED)-A verified staff received orientation to 144G assisted living statutes, but the records may not be complete in the employee files. The licensee's policy titled Personnel Records, dated February 10, 2022, indicated records	0 650		

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0 650	Continued From page 7 related to orientation will be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 650		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730		

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0 730	Continued From page 8 (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to complete a medication assessment and individualized medication management plan for two of five residents (R1 and R5) with 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) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 was admitted to the facility on September 23, 2019, under the facility's comprehensive home	0 730		

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0 730	Continued From page 9 care license. R1 began receiving assisted living services on August 1, 2021. R1's diagnoses included atrial-fibrillation, chronic kidney disease, and Alzheimer's disease. R1's service plan dated August 15, 2022, indicated the resident received assistance with activities of daily living, meals, laundry, housekeeping, and medication management. R5 was admitted to the facility on August 24, 2020, under the facility's comprehensive home care license. R5 began receiving assisted living services on August 1, 2021. R5's diagnoses included spondylosis, low back pain, depression, and dementia. R5's service plan dated September 14, 2022, indicated R5 received assistance with activities of daily living, meals, laundry, housekeeping, and medication management. R1 and R5's medical record lacked documentation a registered nurse completed a medication assessment and individualized medication management plan for each of the residents. On December 21, 2022, at 11:00 a.m., executive director (ED)-A stated medication assessments and individualized medication management plans were completed for residents in accordance with 144G assisted living statutes, but the records might not be complete in the resident files. The licensee's policy titled Resident Records, dated February 10, 2022, indicated resident records would contain an individualized medication management plan and other relevant health records.	0 730		

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0 730	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On December 27, 2022, from approximately 9:45 a.m. to 12:30 p.m., survey staff toured the facility	0 800		

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0 800	Continued From page 11 with the director of maintenance (DM)-G. During the facility tour, survey staff observed the following: 1. The sprinkler heads in the laundry rooms on floors 1 and 3 were covered in a thick layer of lint which could change the temperature at which the sprinklers activate in case of fire. 2. Trash chute doors on floors 1, 2, and 3 did not close and latch independently. The trash chute door should close and latch completely to maintain the fire resistance integrity of the trash chute system. 3. Exit paths were not clear of snow and ice outside exit doors in memory care units. 4. The fusible link was not properly installed on the trash chute cover in the trash room. 5. Third-floor apartments had moisture inside the living room and kitchen light fixtures in apartments 311 and 318. DM-G verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 12 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33959	A. BUILDING: _____ B. WING _____	12/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF RICHFIELD	245 WEST 76TH STREET RICHFIELD, MN 55423

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0 810	Continued From page 13 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 the potential to affect a large portion or all residents). The findings include: During interview on December 27, 2022, at 12:30 p.m., the director of maintenance (DM)-G stated they had not done all the required evacuation drills since August 2021. They also stated the second staff training was scheduled for 12/28/2022. Review of the fire safety policy showed the following: 1. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation. Generic terms like "safe place" were used to describe where residents should be evacuated during an emergency. No clear instructions for staff on how to identify which residents need assistance in an emergency. 2. Record of required employee evacuation drills showed drills completed on 7/29/2022, 09/30/2022, and 10/31/2022. 3. Fire safety and evacuation plan did not include room labels or numbers. At a minimum, all resident rooms should be numbered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

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0 810	Continued From page 14 (21) days	0 810		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to individual residents for five of five employees registered nurse (RN)-B, unlicensed personnel (ULP)-C, ULP-D, ULP-E, and ULP-F with employee records reviewed. This had the potential to affect all residents receiving services. 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: RN-B was hired November 21, 2022, to supervise staff and provide direct care assisted living services to residents of the facility. ULP-C was hired on July 25, 2022, to provide direct care assisted living services to residents of	01480		

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01480	Continued From page 15 the facility. ULP-D was hired on April 20, 2022, to provide direct care assisted living services to residents of the facility. ULP-E was hired on August 10, 2022, to provide direct care assisted living services to residents of the facility. ULP-F was hired on February 17, 2022, to provide direct care assisted living services to residents of the facility. All five employee records lacked documentation of orientation to each individual resident and the resident's needs prior to staff providing services to residents at the facility, in accordance with 144G statutes. When interviewed on December 21, 2022, at 11:00 a.m., executive director (ED)-A stated staff received orientation to 144G assisted living statutes, but the records might not be complete in the employee files. The licensee's policy titled Associate Orientation to Individual Resident, dated February 10, 2022, indicated associates providing services would be specifically oriented to each individual resident and the services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01480		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 16 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for five of five residents (R1, R2, R3, R4, and R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01650		

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01650	Continued From page 17	01650		

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 the potential to affect a large portion or all of the residents).

The findings include:

R1 was admitted to the facility on September 23, 2019, under the facility's comprehensive home care license. R1 began receiving assisted living services on August 1, 2021. R1's diagnoses included atrial-fibrillation, chronic kidney disease, and Alzheimer's disease.

R1's service plan dated August 15, 2022, indicated R1 received assistance with activities of daily living, meals, laundry, housekeeping, and medication management.

R2 was admitted to the facility on September 23, 2019, under the facility's comprehensive home care license. R2 began receiving assisted living services on August 1, 2021. R2's diagnoses included chronic kidney disease, hypertension, and chronic pain.

R2's service plan dated August 15, 2022, indicated R2 received assistance with activities of daily living, meals, laundry, housekeeping, and medication management.

R3 was admitted to the facility on September 1, 2021, under the licensee's assisted living license. R3's diagnoses included hypertension, basal cell carcinoma, and hypothyroidism.

R3's service plan dated September 13, 2022,

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01650	Continued From page 18 indicated R3 received assistance with activities of daily living, meals, laundry, housekeeping, and medication management. R4 was admitted to the facility on August 28, 2021, under the licensee's assisted living license. R4's diagnoses included osteoporosis, vitamin D deficiency, and prediabetes. R4's service plan dated September 22, 2022, indicated R4 received assistance with activities of daily living, meals, laundry, housekeeping, and medication management. R5 was admitted to the facility on August 24, 2020, under the facility's comprehensive home care license. R5 began receiving assisted living services on August 1, 2021. R5's diagnoses included spondylosis, low back pain, depression, and dementia. R5's service plan dated September 14, 2022, indicated R5 received assistance with activities of daily living, meals, laundry, housekeeping, and medication management. All five residents' service plans lacked a contingency plan that included: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wishes to have notified in and emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical	01650		

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01650	Continued From page 19 services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. When interviewed on December 21, 2022, at 11:00 a.m., executive director (ED)-A stated she was unaware that service plans lacked contingency plan language and staff would review the licensee service plan further. The licensee's policy titled, Contents of Service Plans, dated February 10, 2022, indicated service plans would include a contingency plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or	02040		

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02040	Continued From page 20 safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation. During interview on December 27, 2022, at 12:30 p.m., the executive director (ED)-A stated they had not completed a hazard vulnerability assessment on and around the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

DEPARTMENT OF HEALTH

Type: Full
Date: *12/19/22*
Time: 13:50:37
Report: 1036221137

Food and Beverage Establishment Inspection Report

Location:
Havenwood Of Richfield
245 West 76th Street
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0037594
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6122868762
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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO TEMPERATURE INDICATING DEVICE FOR MEASURING SURFACE TEMPERATURE FOR HOT WATER DISH MACHINE AT ESTABLISHMENT. OBTAIN AND MAINTAIN SUCH A DEVICE.

Comply By: 01/19/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

HEAD COOK STACEY CROUD HAS HER SERVSAFE BUT NEEDS TO REGISTER AS A CFPM WITH THE MDH. INSTRUCTIONS FOR APPLICATION EMAILED TO EXECUTIVE DIRECTOR MICHELLE RYAN.

Comply By: 01/19/23

Surface and Equipment Sanitizers

QUATERNARY AMMONIA: = 200 PPM at Degrees Fahrenheit
Location: 3 COMP SINK DISPENSER
Violation Issued: No

HOT WATER: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/BEEF
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CHICKEN
Temperature: 41 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/SLICE TOMATO
Temperature: 40 Degrees Fahrenheit - Location: NORLAKE PREP STATION TOP
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit - Location: NORLAKE PREP COOLER BOTTOM
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 2 Degrees Fahrenheit - Location: NORLAKE REACH IN FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS MAERIN RENEE. INSPECTION CONDUCTED WITH EXECUTIVE DIRECTOR MICHELLE RYAN AND MAINTENANCE DIRECTOR RYAN NELSON. DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- SANITIZER USE AND TEST KITS.
- HAND WASHING POLICY AND REVIEW.
- NO BARE HAND CONTACT WITH RTE FOOD.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING.
- PEST CONTROL.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

**IF ANY RESIDENTS OR STAFF COMPLAIN OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1036221137 of 12/19/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed:_____

MICHELLE RYAN
EXECUTIVE DIRECTOR

Jeff Johanson