DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

February 1, 2022

Administrator
The James, Inc.
10549 Beard Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL28558015

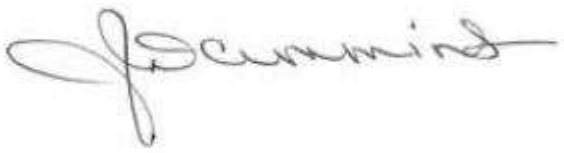
Dear Administrator:

On January 21, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the October 27, 2022, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

pmb

Electronically Delivered

November 24, 2021

Administrator
The James Inc
10549 Beard Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL28558015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 27, 2021, 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 Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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

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), immediate fine imposition is authorized for both surveys and investigations conducted. 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 evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

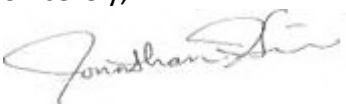
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

INFORMAL CONFERENCE
At any time, the Commissioner of Health is authorized by Minn. Stat. § 144G.20, subd. 20 to hold an informal conference to exchange information, clarify issues, or resolve issues.

The Minnesota Department of Health staff would like to schedule a conference call with Kingsway Retirement Living. Please contact Jonathan Hill at 651-201-3993, on or before Wednesday, December 1, 2021, to schedule the conference call.

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,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28558	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JAMES INC	10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431

(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 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: SL28558015 On October 26, 2021, through October 27, 2021, 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 six (6) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living license Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 subd. 1, 2 and 3SUBDIVISION 11 (b)(1)(2)	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations, had developed and implemented current policies and procedures as required, 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, 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: The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was	0 250		

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0 250	Continued From page 3 placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in	0 250		

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0 250	Continued From page 4 writing, of any changes to this information as required." - "I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page five was electronically signed by the owner on June 18, 2021. The licensee had a Assisted Living license issued on August 1, 2021. During the entrance conference on October 26, 2021, at approximately 12:20 p.m., licensed assisted living director (LALD)-C confirmed he was responsible for and participated in the day-to-day operations. LALD-C stated they were familiar with the Assisted Living with Dementia Care licensing rules. The licensee had attested they read and understood the Assisted Living licensing statutes and rules upon application; however, the following orders were issued: Refer to licensing order at Statute 144G.41 Subd 1. The licensee failed to distribute to residents the current MN Assisted Living Bill of Rights. Refer to licensing order at Statute 144G.42 Subd 6. The licensee failed to provide a written policy or procedure for reporting maltreatment of vulnerable adults. Refer to licensing order at Statute 144G.41, Subd. 1. The licensee failed to develop a staffing plan, as required.	0 250		

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0 250	Continued From page 5 Refer to licensing order at Statute 144G.41 Subd. 1. The licensee failed to ensure food was prepared and served according to the Minnesota Food Code. Refer to licensing order at Statute 144G.10 Subd 2. The licensee failed to have current, up to date, policies and procedures. Refer to licensing order at Statute 1446.41 Subd 3. The licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, ad nursing standards. Refer to licensing order at Statute 144G.42, Subd 1. The licensee failed to display a copy of current Assisted Living license at the main entrance. Refer to licensing order at Statute 144G.42 Subd 2. The licensee failed to evaluate the quality of care by not engaging in quality management. Refer to licensing order at Statute 144G.42 Subd. 7. The licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in common areas and near telephones provided by the assisted living facility. Refer to licensing order at Statute 144G.43 Subd. 8. The licensee failed to ensure the employee record contained all the required content. Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to develop and maintain a tuberculosis (TB) prevention and control program.	0 250		

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0 250	Continued From page 6 Refer to licensing order at Statute 1446.45 Subd 2. The licensee failed to ensure smoke alarms were in working order. Refer to licensing order at Statute 144G.50, Subd. 2 (a). The licensee failed to maintain the physical environment in a continuous state of good repair and operation. Refer to licensing order at Statute 144G.45, Subd. 2. The licensee failed to provide documentation of policy, schedule, and log of staff training for fire, safety, and evacuation procedures. Refer to licensing order 144G.45, Subd 3. The licensee failed to comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. Refer to licensing order at Statute 144G.50, Subd. 1. The licensee failed to develop, implement, and provide a contract containing all required content to all residents. Refer to licensing order at Statute 1446G.62 Subd 5. The licensee failed to supervise staff that performed delegated nursing tasks. Refer to licensing order at Statute 144G.63 Subd 2. The licensee failed ensure staff that supervised direct services complete an orientation to assisted living licensing requirements. Refer to licensing order at Statute 144G.63 Subd 5. The licensee failed to ensure staff performing direct services completed at least 8 hours of annual training for each 12 months of	0 250		

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0 250	Continued From page 7 employment. Refer to licensing order at Statute 144G.64, (a). The licensee failed to ensure all employees had completed training in dementia care, as required. Refer to licensing order at Statute 144G.70, Subd. 4. The licensee failed to develop and implement a service plan for all residents. Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to ensure each resident receiving medication management services had an individualized medication management plan containing all required content. Refer to licensing order at Statute 144G.72 Subd 2. The licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. Refer to licensing order at Statute 144G.71, Subd. 22. The licensee failed to ensure all required content for disposition of medications was documented in R4's record. Refer to licensing order at Statute 144G.81, Sub. 1. The licensee failed to provide the proper documentation that a hazard vulnerability or safety risk assessment had been performed on and around the property. Refer to licensing order at Statute 144G.90, Subd. 1. The licensee failed to provide the current Assisted Living Bill of Rights to all residents. Refer to licensing order at Statute 144.6502, Subd. 8. The licensee failed to ensure required postings notifying visitors of electronic monitoring was posted at facility entrances.	0 250		

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0 250	Continued From page 8 Twenty-eight (28) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules was limited or not evident for compliance with sections 144G.08 to 144G.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide current Minnesota Assisted Living Bill of Rights (BOR) for two of two residents (R1, R2) with records reviewed. 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	0 450		

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0 450	Continued From page 9 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R2's record lacked written acknowledgement for the current assisted living BOR released May 2021. R1's record included an older version of BOR signed by R1 on March 24, 2015. R2's record lacked written acknowledgement of receipt of current BOR. On October 27, 2021, at approximately 9:00 a.m., Licensed Assisted Living Director (LALD)-C acknowledged BORs in resident records were not the current versions. LALD-C stated they did not know a newer version was released and only the older versions were included in all resident records. LALD-C stated they had the January 2014 version provided to all residents, and they would need to update their acknowledgement form to ensure the current BOR version will be provided. The licensee lacked a current policy for resident acknowledgement of the Minnesota Assisted Living Bill of Rights. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		

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(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
0 470	Continued From page 10	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (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 interview and record review, the licensee failed to develop, or implement a staffing plan to determine its staffing level. This had the potential to affect all six (6) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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	28558	A. BUILDING: _____ B. WING _____	10/27/2021

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0 470	Continued From page 11 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: The licensee held an assisted living license effective August 1, 2021. Licensee was licensed for a resident capacity of 6 residents and had a current census of 6 residents. During the entrance conference on October 26, 2021, at approximately 12:30 p.m., licensed assisted living director (LALD)-C explained how the licensee staffed its building as part of its staffing plan and indicated that their daily schedule would be considered their staffing plan. A written staffing plan was not developed. The licensee lacked a current policy for developing a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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: (i) at least three nutritious meals daily with snacks	0 480		

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0 480	Continued From page 12 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 ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all six (6) residents in the Assisted Living 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated October 6, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 500	Continued From page 13	0 500		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or	0 500		

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0 500	Continued From page 14 licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure by attesting the managerial officials who oversaw the day-to-day operations, had developed, and implemented current policies and procedures, as required, 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, 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: During entrance conference on October 26, 2021, at approximately 12:30 p.m., licensed assisted living director (LALD)-D stated he reviewed the current assisted living regulations on-line and confirmed that he had developed, and implemented current, up to date, policies and procedures. The licensee failed to ensure the following policies and procedures were in place and kept current: - requirements in section 626.557, reporting of	0 500		

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0 500	Continued From page 15 maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; - supervision of unlicensed personnel performing delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as	0 510		

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0 510	Continued From page 16 applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19. The licensee failed to ensure staff and visitors entering or re-entering the building were screened for COVID-19 with documented temperatures and symptom screening questions. The licensee failed to ensure staff wore eye protection while working in the facility. The licensee failed to ensure that two of two residents (R1, R2) were monitored and screened daily for COVID-19 symptoms. This had the potential to affect all six (6) residents, staff, and visitors 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 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: PERSONAL PROTECTIVE EQUIPMENT AND STAFF/VISITOR SCREENING The Minnesota Department of Health (MDH)	0 510		

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0 510	Continued From page 17 guidance titled, "COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Settings," dated April 23, 2021, indicated on page 1 of 3, heath care worker (HCW) with face-to-face contact with COVID-19 negative clients were to wear eye protection. The Minnesota Department of Health's (MDH) electronic, COVID-19 Toolkit: Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 7: Screen all staff and visitors for fever and symptoms of illness before entering facility common areas. On October 26, 2021, at approximately 12:05 p.m., registered nurse (RN)-A greeted writer at entrance, wearing a face mask. RN-A was noted to have no eye protection on. RN-A allowed writer entrance and did not provide any symptom screening for COVID-19, including not performing a temperature assessment using a thermometer. There were no postings regarding wearing any personal protective equipment or any posting related to COVID-19. RN-A instructed writer to sit at kitchen table and wait for the licensed assisted living director (LALD)-C to arrive. On October 26, 2021, at approximately 12:12 p.m., there was a knock on the entrance door in which RN-A proceeded to open door and allow a visitor to enter. Visitor was noted to be wearing a hood on head with no mask or eye protection. RN-A asked visitor to sign a sheet indicating the identity of the visitor. There was no symptom screening for COVID-19 as well as no temperature taken. Visitor then proceeded to enter and walked to resident room. On October 26th, 2021, at approximately 12:25 p.m., LALD-C arrived to and entered wearing a	0 510		

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0 510	Continued From page 18 face mask with no eye protection. There was no screening done for LALD-C by any staff member. LALD-C proceeded to set down briefcase and sit at table where writer was located. On October 26, 2021, at 1:45 p.m., LALD-C stated he was not aware it was still required to screen visitors, or staff for COVID-19 nor was LALD-C aware of the requirement for personal protective equipment. LALD-C stated he thought that these requirements had ended and had not been told that they were to continue. RESIDENT COVID-19 MONITORING AND SCREENING The Minnesota Department of Health (MDH) guidance titled, "COVID-19 Toolkit," dated March 8, 2021, indicated all residents should be actively screened for fever and respiratory symptoms at least daily. Daily pulse oximeter screening was recommended. Chart all clinical measurements and symptoms for each resident. The licensee lacked evidence that R1 and R2 were monitored for oxygen saturation levels and temperatures. R1 and R2 were not screened for COVID-19 symptoms daily. On October 28, 2021, at approximately 9:25 a.m., LALD-C confirmed the licensee did not have a written policy for screening of COVID-19 nor was there a policy for the requirement of personal protective equipment to be worn. The licensee's infection control policy was requested, but not provided. No further information was provided.	0 510		

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0 510	Continued From page 19 TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all of the licensee's current 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	0 550		

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0 550	Continued From page 20 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: The licensee lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). During an observation of facility on October 26, 2021, at approximately 12:25 p.m., it was observed the common areas lack the required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC. On October 26, 2021, at approximately 2:45 p.m., licensed assisted living director (LALD)-C confirmed the required content noted above was not posted as required. The licensee lacked a current vulnerable adult maltreatment-prevention and reporting policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		

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0 570	Continued From page 21	0 570		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to display the current assisted living license at the main entrance of the assisted living building. 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: During an observation on October 26, 2021, at approximately 12:15 p.m., there was no original current license posted at entrances, hallways, dining areas, or in living areas. On October 26, 2021, at approximately 2:15 p.m., licensed assisted living director (LALD)-C stated that there was a current assisted living license dated for August 1, 2021, but the license had not been posted as of yet. LALD-C stated the license was located at his office, not located at the assisted living. No further information provided.	0 570		

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0 570	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all three residents receiving assisted living 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, 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).	0 580		

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0 580	Continued From page 23 The findings include: On October 26, 2021, during a 1:19 p.m. interview, licensed assisted living director (LALD)-C stated the licensee had not documented any quality management activities. The licensee's Quality Management Project policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting	0 640		

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0 640	Continued From page 24 Center and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all six (6) residents receiving assisted living 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, 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: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living. In addition, there was no evidence of the contact information or reporting number for MAARC in any common area or near any phone. During a facility observation on October 26, 2021, at approximately 1:45 p.m., the surveyor noted the facility's common areas had no posting of the 911 emergency number or information related to reporting suspected maltreatment to MAARC. During an interview on October 26, 2021, at 2:29 p.m., licensed assisted living director (LALD)-C verified the required information was not posted in the common areas. The licensee lacked a current vulnerable adult and maltreament policy. No further information was provided.	0 640		

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(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
0 640	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	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. This MN Requirement is not met as evidenced	0 650		

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0 650	Continued From page 26 by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of two employees (RN-A) 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A had a hire date of September 25, 2006. RN-A's record lacked evidence of a performance review since date of hire. On October 27, 2021, at 9:12 a.m., licensed assisted living director of nursing (LALD)-C indicated RN-A has not had a current performance evaluation due to facility challenges. The licensee lacked a current employee file policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 27 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screenings were completed and documented for one of two staff, registered nurse (RN)-A, with 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), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	0 660		

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0 660	Continued From page 28 The facility TB risk assessment dated August 1, 2021, indicated the facility was a low risk setting for TB transmission. RN-A was hired September 25, 2006, and provided direct cares for residents of the assisted living. RN-A's employee record included a chest xray indicating RN-A tested positive after having a two-step Mantoux completed. RN-A's record lacked documentation of a TB history and symptom screening form. On October 27, 2021, during a 9:39 a.m. interview, licensed assisted living director (LALD)-C stated RN-A had a positive TB skin test prior to hire and a negative chest x-ray but was not aware that RN-A did not have a symptom screening completed. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's tuberculosis screening policy was requested but not provided.	0 660		

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0 660	Continued From page 29 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the battery in the smoke alarm in a resident room #2 failed. This had the potential to directly affect all residents and staff.	0 780		

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0 780	Continued From page 30 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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 27, 2021, at 9:35 a.m., survey staff toured the assisted living with the licensed assisted living director(LALD-C). It was observed that the smoke alarm in bedroom number #2 when tested by LALD-C did not alarm. LALD-C verified this observation by stating that the smoke alarm just needs new batteries. No further inofrmation was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790		

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0 790	Continued From page 31 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the installation and maintainance of the fire extinguisher in compliance with the requirements of the MN State Fire Code as required by MN Statute 144G.45 subd.2(a)(2). 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 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 included: On October 27, 2021, at approximately 9:25 a.m., the portable fire extinguisher located near the front entrance door was observed with no tags attached to show the required annual service and monthly inspections from this year, or any previous years. The licensed assisted living director (LALD)-C verified the observation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800	Continued From page 32	0 800		
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 observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. 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 October 27, 2021, between 9:16 a.m. and 10:30 a.m. survey staff begin the tour with the licensed assisted living director (LALD)-C but was replaced with the registered nurse (RN)-A at 9:50 a.m. for the remaining of the tour. ENTRANCE and RESIDENT COMMUNITY AREAS	0 800		

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0 800	Continued From page 33 On October 27, 2021 at approximately 9:30 a.m., it was observed the floor, based trims, and walls throughout the facility are heavily stained, layered with accumulation of dirt and lacked of continuous cleaning to maintain the faciltiy in an acceptable state of cleanliness. This was confirmed with LALD-C. MAIN FLOOR BATHROOM On October 27, 2021 at approximately 9:55 a.m. the following findings were observed for the the bathroom on the main floor: 1. The shower ceiling consists of peeled paint, damaged sheetrock, showed signs of discoloration from excess moisture consisting of mold or potential for continued mold growth. 2. The tile shower compartment showed dark staining on the tile grout throughout the wall and floor of the compartment. 3. The floor and coved bases were stained and dirty in the bathroom. 4. The exhaust fan was heavily layered with thick dust. The RN-A verified the above observations and findings during the tour but was also discussed and verified with LALD-C at the exit interview at 10:30 a.m.. BEDROOM 4 On October 27, 2021 at approximately 10:00 a.m., it was observed the cover for the light switch in Room 4 was missing and the floor and floor trims were layered with accumulation of dirt, and air supply/return grilles are dusty. This was verified with the RN-A. BEDROOM 6 (Lower Level) On October 27, 2021 at approximately 10:15 a.m., the following findings were observed: 1. The bedroom ceiling near the clothes closet	0 800		

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0 800	Continued From page 34 and the supply grille, was heavily damaged showing sagging of sheetrock with signs of water leakage from the above bathroom shower or piping, and the sheeetrock also showed signs of discoloration from excess moisture consisting of mold or potential for continued mold growth. 2. The supply grille next in the same area where damage ceiling was not secured and loose from the damaged drywall due to leak from above item 1. 3. The carpet was heavily stained and soiled. 4. The resident's room was cluttered and and uncleaned, and not in good state of cleaniness and repair. The RN-A verified the above findings as she aknowledged and explained the challenge and resident's approval to access for cleaning in Room 6. This was also verified with the LALD-C at the exit interview at 10:30 a.m. THE KITCHEN CEILING On October 27, 2021 at approximately 10:25 a.m., it was observed that the popcorn texture ceiling above the kitchen area was soiled, stained, with discoloration. The popcorn ceiling is not considered a smooth and a cleanable surface. This was verified with the RN-A. This was also verified with LALD-C at the exit interview at 10:30 a.m. No other 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	0 810		

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0 810	Continued From page 35 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the required documentation on fire safety and evacuation plans, as well as required evacuation drills. In addition, the facility failed to provide	0 810		

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0 810	Continued From page 36 documentation on staff and resident training and training frequency related to evacuation. This has the potential to directly affect the safety of 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 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 October 27, 2021, between 9:16 a.m. to 10:30 a.m., survey staff asked for the facility fire safety and evacuation plan documentation, drills, and training records for review. The licensed assisted living director (LALD)-C indicated the documentation is in an electronic format, but documentation was not made available for review. 1. No evacuation plan or documentation on specific procedures for employee fire drill actions, fire protection procedures necessary for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during evacuation especially for residents who are wheelchair bound and needing assistance during evacuation. 2. No posting of fire safety or evacuation plan posted and readily available in case of fire or emergency evacuation. 3. No records of required employee evacuation drills. A minimum total of six are required	0 810		

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0 810	Continued From page 37 annually. 4. No schedule and required records on training of employees on fire safety and evacuation. 5. No required records on training of residents who are capable of assisting their own evacuation on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. Fire safety and evacuation plans must be established and readily available at all times within the facility. Employees are required to complete evacuation drills and performed training. Failure to provide these plans, training and drills can cause confusion and delay response time for evacuation of residents and employees during a fire or emergency. On October 27, 2021, at approximately 10:30 a.m., the LALD-C verified the findings as he was not able to provide the information listed above, as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the applicable state and	0 830		

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0 830	Continued From page 38 local governing laws, including the MN State Fire Code for safe egress. This has the potential to directly affect safety of four residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 27, 2021, at approximately 9:20 a.m., survey staff toured with licensed assisted living director (LALD)-C , and measured the egress window sill (opening) height above the floor to be at 56 inches. MN State Fire Code requires the height to be at maximum of 48 inches above the floor for existing required egress windows for facilities licensed by the State of Minnesota (see Minn. State Fire Code parts 1104.26.1 subp. 2 and 1104.26.3). This finding was verified with LALD-C. He stated the bedrooms on the main floor are of the same window type with the same opening height of 56 inches from the floor. LALD-C also explained that the home was built in the 1950s and that the local officials have been out to review the windows for compliance with local laws which survey staff explained that this was determined prior to passed legislation which took effect on August 1, 2021, for statewide licensing of assisted living facilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		

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01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (ULP)-B with employee record reviewed. 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	01440		

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01440	Continued From page 40 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of September 15, 2021. ULP-B's employee record lacked documentation of direct supervision to verify that the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On October 26, 2021, at 2:00 p.m., registered nurse (RN)-A verified ULP-B's employee record lacked documentation of direct supervision. The licensee's policy on supervision was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility.	01460		

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01460	Continued From page 41 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of one employee, registered nurse (RN)-A with employee record 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), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A's employee record indicated RN-A started providing direct care services on September 25, 2006. RN-A lacked the required orientation to assisted living licensing requirements and regulations with the required content. On October 26, 2021, at 2:30 p.m., licensed assisted living director (LALD)-C verified the lack of employee records for RN-A. RN-A and the LALD-C stated they were unable to verify RN-A's orientation to the assisted living licensing requirements and regulations. The licensee lacked a policy for orientation and annual training. No further information was provided.	01460		

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01460	Continued From page 42 TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning	01500		

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01500	Continued From page 43 and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the 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 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of one employees, registered nurse (RN-A), with 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), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01500		

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01500	Continued From page 44 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-A's employee records lacked any evidence of annual training. RN-A had a hire date of September 25, 2006. On September 15, 2021, at 3:55 p.m., licensed assisted living director (LALD)-C stated he was not aware RN-A's employee record lacked documentation of annual training. LALD-C stated he believed all staff would have received annual training. The licensee lacked a current policy for annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working	01530		

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01530	Continued From page 45 hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial 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 interview, and record review, the licensee failed to ensure one of one employee, registered nurse (RN)-A), received the required amount of dementia care training in the required time frame 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Registered Nurse (RN)-A's record lacked documentation of the required eight (8) hours of dementia training within 120 working hours of the employment start date. RN-A's hire date was September 25, 2006. RN-A	01530		

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01530	Continued From page 46 did not have had eight (8) hours of dementia training completed by August 24, 2021. On September 30, 2021, at approximately 11:00 a.m., RN-A stated she did not complete eight (8) hours of dementia training at this job but believed she had completed training at another employer. RN-A did not provide any documentation of annual dementia training. The licensee lacked a policy for employee orientation. No further information provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01530		
01650 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (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	01650		

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01650	Continued From page 47 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 observation, interview and record review, the licensee failed to ensure resident service plans included all the required content for two of three residents (R1, R2) 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, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's service plan dated June 11, 2015, lacked the following: -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;	01650		

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01650	Continued From page 48 and -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. R2's service agreement dated November 25, 2018, indicated R2 received services including medication administration. The service plan lacked the following: -method of supervision and monitoring of staff -service plan agreement lacked a name and phone number for an emergency contact or any information in regards to who had the authority to sign for the resident in an emergency. On October 26, 2021, at 3:35 p.m., licensed assisted living director (LALD)-C verified both R1 and R2's record lacked the above information. The licensee lacked a current service plan policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's	01730		

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01730	Continued From page 49 assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment and developed a medication management plan to determine what and how medication	01730		

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01730	Continued From page 50	01730		

management services would be provided for one of one resident (R1) 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's record lacked a medication management plan developed prior to providing medication management services and lacked evidence the RN conducted an assessment to include:
- an identification and review of all medications the resident was known to be taking.

R1 began receiving services on June 11, 2015, under the comprehensive home care license with diagnoses that included, but were not limited to, quadriplegia.

R1's Service Plan Agreement dated June 11, 2015, noted R1 was reliant on staff assistance for wound care, catheter care, and medication administration.

R1's prescriber's orders dated September 25, 2018, included but, were not limited to, a pain reliever, antidepressant, antacid, and laxative.

On October 26, 2021, at approximately 2:44 p.m., licensed assisted living director (LALD)-C verified R2's record lacked a medication management plan and stated he was not aware that a separate

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01730	Continued From page 51 plan was required. RN-A was not aware what had been used to identify the medications the resident was taking to complete the assessment. The licensee's medication, treatment and therapy reminders policies were requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement and	01930		

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01930	Continued From page 52 maintain up-to-date written treatment or therapy management policies and procedures 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, 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: During the entrance conference on October 26, 2021, at approximately 12:25 p.m., RN-A confirmed the licensee provided treatment management services which included, but were not limited to, providing services for catheter care, wound care, and compression stocking application and removal. A request was made to review the licensee's policies and procedures. On October 26, 2021, at approximately 3:25 p.m., licensed assisted living director (LALD)-C stated he would look for the above policies; however, they were not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors	03090		

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03090	Continued From page 53 Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all six (6) residents residing in the assisted living facility, staff, and any visitors of the licensee. 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 finding include: On October 26, 2021, at approximately 12:15 p.m., the surveyor observed the facility's common areas and noted the lack of signage posted with the required verbiage regarding electronic monitoring. On October 27, 2021, during the 9:40 a.m. exit	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28558	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JAMES INC	10549 BEARD AVENUE SOUTH BLOOMINGTON, MN 55431

(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
03090	Continued From page 54 conference, licensed assisted living director (LALD)-C verified there was no signage posted indicating electronic monitoring. LALD-C stated he was not aware this was a requirement as the licensee did not have any electronic monitoring. The licensee's electronic monitoring policy was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *10/26/21*
Time: 13:30:00
Report: 1025211297

Food and Beverage Establishment Inspection Report

Location:
The James Inc
10549 Beard Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: NHFID28
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #:
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.

4-700 Sanitizing Equipment and Utensils

4-703.11C ** Priority 1 **

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

Sanitize clean utensils and food contact surfaces between uses; see additional comments.

Comply By: 10/26/21

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 three-compartment sink to wash, rinse, and sanitize utensils and food contact surfaces; see additional comments.

Comply By: 10/26/21

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Provide a food thermometer, as described above, and use to test final cooking temperatures for foods (raw animal food, frozen meals). See additional comments.

Comply By: 10/27/21

5-200A Plumbing: approved materials/design

5-203.11A ** Priority 2 **

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

Provide a dedicated handwashing sink for the kitchen; see additional comments.

Comply By: 10/26/21

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

Replace ornamental metal knot cabinet handles (high touch surface) with a smooth, easily cleanable handle or knob.

Comply By: 11/02/21

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

Provide a means of chemical sanitation which carries a label for "food contact use." Mix and use following label directions.

Comply By: 10/26/21

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

Clean and maintain cabinet fronts, cabinet interiors, back-splash behind and above oven/range.

Comply By: 11/02/21

Food and Equipment Temperatures

Process/Item: Ambient
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Freezer (chest)
Temperature: Degrees Fahrenheit - Location: Frozen
Violation Issued: No

Process/Item: Freezer (upstairs)
Temperature: Degrees Fahrenheit - Location: Frozen
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

The James Inc
10549 Beard Avenue South
Bloomington, MN 55431

Discussed food preparer health and hygiene (do no prepared food if ill with vomiting, diarrhea, or other communicable disease which may be spread through food), washing/rinsing/sanitizing of food contact surfaces and utensils, food temperatures, TCS foods for same-day service, finishes, food and chemical storage, food source (reported Wal-Mart and Sam's Club). Menu is fixed. Majority of meals are prepared from frozen. No food preparation sink in the establishment; food preparation sinks are needed if serving or preparing unwashed fruits and produce, or thawing under cold running water.

MDH Employee Hygiene:
https://www.health.state.mn.us/communities/environment/food/docs/fs/emplyhygnfs.pdf

Food storage: reported food stored in kitchen and downstairs chest freezer only. Do not store food in private residences or non-licensed spaces. Obtain food from approved sources (e.g. grocery stores). Provide containers for food storage which are intended to be multi-use and which can withstand repeated washing and sanitizing.

Washing, rinsing, sanitizing: Dishwasher does not have a sani-rinse function (reported not in use), and is not a unit which can provide a contact temperature of 160 deg F. Kitchen has a two-compartment sink. Provide a wash basin/bus tub/or container large enough to fully submerge the largest piece of cooking equipment (pans, dishes, etc) and use a chemical sanitizing procedure. Discussed using unscented bleach as one available option, from a bottle labeled for food-contact use, at 1/2 to 1 tea (1 capful) per gallon to achieve approximately 50-100 PPM, with a contact/soak time of at least 1 minute, and then let air dry. Verify using a chlorine/bleach test kit if mixing a sanitizing solution (these can be found online).

MDH Cleaning and
Sanitizing:https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf

The available Odoban chemical for cleaning and disinfecting is not labeled for food contact use. Recommend using a granite cleaner for the countertops, and a chlorine solution (50-100PPM) to sanitize food contact surfaces. Cutting boards should be used on top of granite, as granite is a solid surface but technically porous. Granite can also be damaged by some cleaners and sanitizers.

Food temperatures: cook foods to the temperature indicated on package for frozen meals (usually, this is listed as 160 deg F). Provide a food thermometer (digital, and with a thin metal probe) to verify foods are cooked to the correct temperature.

The refrigerator interior temperature should be at 41 deg F or below. An oven thermometer (beginning at ~150 deg F) was in the refrigerator; replace with a cooler thermometer. Temperatures can also be monitored using a food thermometer.

MDH Cooking temperatures for food:

https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
MDH TCS foods: https://www.health.state.mn.us/communities/environment/food/docs/fs/tcsfoodfs.pdf

Handwashing: Visitors are instructed to wash hands in the restroom. Food preparers wash hands in the kitchen. Paper towels are kept in a drawer to prevent residents from disposing of them in waste plumbing. Wash hands prior to working in the kitchen; gloves are available for use. Technically, per code, a separate handwashing sink needs to be provided, but use the available kitchen sink until provided.

MDH Employee Handwashing:
https://www.health.state.mn.us/communities/environment/food/docs/fs/handwashfs.pdf
MDH Hand Hygiene: https://www.health.state.mn.us/communities/environment/food/docs/fs/nohandcontfs.pdf

Cleaning: Clean high-touch areas on cabinets and handles. Replace the drawer knobs with knobs that are easy to clean (not ornamental), like a simple, smooth handle or pull. A new coat of high-gloss paint may be appropriate for cabinets (once clean) to help with future cleaning, and to cover up areas where paint has worn away and has exposed the wood underneath.

MDH Construction Guide:
https://www.health.state.mn.us/communities/environment/food/docs/license/feconstguide.pdf

Hollow enclosed bases on cabinets: Hollow enclosed bases are prohibited in food preparation areas, as they provide harborage areas for pests. Clean under cabinets and install legs (if the floor finish extends underneath to the walls), or fill spaces with rigid sheet foam (not spray foam). Contact prior to making major changes to make sure they would be approved.

Chemical storage: in closest beside kitchen. No food or supplies were observed in the chemical storage area. Medication was stored in a separate door compartment from food in an appropriate way.

Date marking: Opened items in the refrigeration were date marked.

TCS Foods for Same-Day Service Only: TCS foods (perishable foods, cooked meals, meats, dairy, cut leafy greens like spinach, sliced tomatoes, eggs, etc) may be prepared and served for same-day service only to for the establishment to be exempt from 4626.0506 (eg commercial equipment). Effectively, this means foods cannot be prepared more than one day in advance, or leftovers cooled for re-service. Residents private items are theirs, and if they are not the establishments to serve, residents may do with them as they wish, as long as they remain separate from food belonging to and served by the establishment.

Equipment requirements (when TCS foods are served for multi-day service):
https://www.health.state.mn.us/communities/environment/food/docs/fs/equipreqfs.pdf

Storage order: store raw meat and eggs as low as possible in the refrigerator to prevent contamination if an item breaks or leaks.

Microwave cooking: Raw animal foods, if ever cooked in the microwave, must be heated to a temperature of at least 165 degrees F (74 degrees C) in all parts of the food, and allowed to stand covered for 2 minutes after cooking to obtain temperature equilibrium.

Grease-laden vapors: Maintain the cooking area clean; grease-laden vapors from cooking will deposit grease on surfaces and could create a fire hazard. Over-range microwaves may sometimes provide minor filtration of vapors but are not true exhaust systems. Some sort of system may be beneficial for this property to prevent build-up of grease above the range.

Physical facilities:
Provide a smooth ceiling surface in the kitchen (rough stipple/acoustical currently in kitchen) with a smooth, easily cleanable finish.

Provide a smooth cabinet finish for easy cleaning; seal holes and any exposed wood.

MDH Allergen Information:
https://www.health.state.mn.us/communities/environment/food/docs/fs/majfoodallfs.pdf
MDH Highly Susceptible Populations:
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

Sign up to receive MDA food recall notification via email:
Search: "MDA Recall"
Visit: https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

Above items reviewed on-site with Joy (PIC) and E Jones (MDH).

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 1025211297 of 10/26/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Joy

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