Electronically Delivered

February 23, 2024

Licensee
The Willows
2918 7th Avenue North
Anoka, MN 55303

RE: Project Number(s) SL24668015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 31, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24668	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	2918 7TH AVENUE NORTH ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL24668015-0 On January 29, 2024, through January 31, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were seven residents, all of whom were receiving services under the 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 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	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.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control for one of two unlicensed personnel ((ULP)-F). 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: On January 30, 2024, from 1:38 p.m., through 1:47 p.m., the surveyor observed ULP-F enter R3's room and don gloves after performing hand hygiene. ULP-F assisted R3 from wheelchair to bed with the help of another ULP using a full mechanical lift. ULP-F provided peri care to R3 and removed a urine soiled incontinence pad and placed it on the floor next to R3's bed. ULP-F doffed gloves, and without performing hand	0 510		

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0 510	Continued From page 3 hygiene, ULP-F donned clean gloves and assisted R3 with placing a clean brief and pants. ULP-F then placed the soiled incontinence pad in a garbage outside of R3's bedroom. ULP-F then doffed gloves and washed hands in the kitchen sink. On January 30, 2024, at 1:47 p.m., ULP-F stated, "I should have thrown it away right away I don't usually put it on the floor, but I forgot to look to see if the garbage can was in there." On January 30, 2024, at 1:50 p.m., licensed assisted living director (LALD)-C stated, "All our staff are trained to follow good infection control and hand washing practices, and they should have thrown the brief in the garbage right away and not have set it on the floor so we will do some more education." The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers guidance dated January 30, 2020, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. The licensee's 8.01 Infection Control Policy dated April 25, 2023, read, "WPAL's infection control program will be consistent with current requirements and mandates from CDC for prevention control in assisted living facilities." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		

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0 680	Continued From page 4	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. This practice resulted in a level two violation (a	0 680		

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0 680	Continued From page 5 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency and disaster preparedness plan dated April 7, 2023, lacked evidence of the following required content: - identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - strategies for addressing facility surges/shortages; and - emergency prep testing requirements. On January 30, 2024, at 11:15 a.m., licensed assisted living director (LALD)-C stated they did not have the above listed contents and they were not aware the contents were missing. LALD-C took a note of the contents and stated it was something they have to work on. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 6 (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 licensee failed to provide smoke alarms outside in the immediate vicinity of all sleeping rooms in the facility. This had the potential to directly affect a limited number of 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 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).	0 780		

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0 780	Continued From page 7 Findings include: On a facility tour on January 29, 2024, at 1:45 p.m., with licensed assisted living director (LALD)-C and maintenance (M)-E, it was observed that smoke alarms were not provided outside and in the immediate vicinity of resident sleeping room number 4. All dwelling units are required to be provided with smoke alarms outside in the immediate vicinity of all sleeping within the dwelling unit. During the tour LALD-C and M-E, stated there was not a smoke alarm located outside resident sleeping room number 4 and they would install one that immediate area. TIME PERIOD FOR CORRECTION: One (1) day.	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 Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 790		

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0 790	Continued From page 8 failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at 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 a facility tour on January 29, 2024, at 2:00 p.m., with licensed assisted living director (LALD)-C and maintenance (M)-E, it was observed that the required fire extinguisher located on the main floor was under the kitchen sink in a cabinet with lockable hardware and not mounted at least 4 inches off the floor surface. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During interview on January 29, 2024, at 2:10 p.m., LALD-C and M-E stated the fire extinguisher was in the marked cabinet with	0 790		

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0 790	Continued From page 9 lockable hardware under the kitchen sink and not mounted off the floor surface at least 4 inches. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 800		

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0 800	Continued From page 10 On a facility tour on January 29, 2024, at 2:00 p.m., with licensed assisted living director (LALD)-C and maintenance (M)-E, the surveyor made the following observations of facility hazards and disrepair: There were 5 holes in the garage side drywall wall covering in the fire-resistant wall between the occupied assisted living and the attached garage above the entry door leading into the facility from the garage. There was also one hole in the garage side of the drywall wall covering behind the step leading into the house from the garage. The fire resistant wall between the facility and attached garage is required to be maintained free of holes and sealed to prevent the passage of smoke or fire from one side of the wall to the other in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511. An electrical outlet cover was missing on the exterior back deck to the left of the door leading out to the back deck. Electrical outlet covers are required to be maintained according to Minnesota Fire Code in Minnesota Rules Chapter 7511. There were rotten deck boards with deep deterioration from weather exposure on the back deck surface. The window hardware was broken on the emergency escape and rescue opening window in resident sleeping room number 5 in the basement. The window hardware was removed by M-C so the window can swing open all the way in an emergency, but the hardware and bottom window stop are in need of repair. Emergency escape and rescue openings are required to be maintained in working condition for immediate use in the event of a fire or similar emergency	0 800		

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0 800	Continued From page 11 according to Minnesota Fire Code in Minnesota Rules Chapter 7511. During a facility tour on January 29, 2024, at 2:00 p.m., LALD-C and M-E verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

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0 810	Continued From page 12 (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, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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 January 29, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C and licensed practical nurse (LPN)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP undated, failed to include the following:	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24668	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	2918 7TH AVENUE NORTH ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include in writing and available the evacuation needs (status) for each individual resident in the assisted living facility. During an interview on January 29, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C, stated the evacuation needs for each individual resident were not provided in the plan in writing and immediately available for reference in the event of a fire or similar emergency. TRAINING Record review indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation the residents had been offered the training. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation the employees were trained as required. During an interview on January 29, 2024, at 2:45 p.m., LALD-C, stated the training for employees was completed one time in the past year but documentation was not available. It was also stated by LALD-C documentation that training was provided to residents was not available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24668	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	2918 7TH AVENUE NORTH ANOKA, MN 55303

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01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were transcribed per providers orders for one of two residents (R2). 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: R2's diagnoses included Multiple sclerosis, traumatic brain injury, Raynaud's disease hypertension, depression, insomnia, and early	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24668	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	2918 7TH AVENUE NORTH ANOKA, MN 55303

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01760	Continued From page 15 onset Alzheimer's disease. R2's signed Service Plan dated March 13, 2023, indicated R2 received assistance with bathing, dressing, grooming, ambulation, and medication management. R2's medication administration record (MAR) Summary dated January 1, 2024, to January 31, 2024, included the following as needed (PRN) medications: -Benzonatate 100 milligrams (mg) capsule (cap), one cap three times by mouth daily if needed; -Docusate sodium (Na) 100mg softgel, one cap by mouth daily if needed; -Ibuprofen 600mg tablet (Tab), take tab by mouth every six hours as needed for pain; -Loperamide 2mg Cap, take two caps by mouth initially then one cap after each loose stool (maximum 16mg/day) -Ondansetron Hcl 4mg tab, by mouth every six hours as needed; and -Senna 8.6mg tab, take one tab by mouth everyday as needed. Physician order signed and dated September 21, 2023, included the following: -Benzonatate 100 milligrams (mg) capsule (cap), one cap three times by mouth daily if needed; -Acetaminophen 500mg by mouth every 8 hours PRN for pain/fever (do not exceed 4000mg/24 hours); -Ibuprofen 600mg tablet (Tab), take tab by mouth every six hours as needed for pain; -Loperamide 2mg Cap, take two caps by mouth initially then one cap after each loose stool (maximum 16mg/day) -Ondansetron Hcl 4mg tab, by mouth every four hours as needed; and -Senna 8.6mg tab, take one tab by mouth everyday as needed.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24668	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	2918 7TH AVENUE NORTH ANOKA, MN 55303

(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
01760	Continued From page 16 On January 30, 2024, at 8:55 a.m., the surveyor inquired why Ondansetron Hcl 4mg tab was entered into the MAR to be given every six hours, when Physician order reads every four hours. Docusate Na 100mg, was not on the physician order but it was on the MAR. Acetaminophen 500mg by mouth every 8 hours PRN for pain/fever (do not exceed 4000mg/24 hours) was on the physician order but it did not get transcribed to the MAR. Licensed practical nurse (LPN)-A stated pharmacy entered the orders for all medication into the MAR and sent print outs to the facility. Docusate was discontinued February 2023, and acetaminophen order was changed to PRN on April 23, 2023, but did not get transcribed accordingly by pharmacy. LPN-A stated they should have double checked the MAR for accuracy, but it was overlooked. The licensee's 7.17 Medication & Treatment Orders-Receiving policy read: "POLICY: An RN (registered nurse), LPN, therapist, or person at WPAL who is qualified to receive orders will obtain all medications and treatment orders either in writing, verbally, or electronically by an authorized prescriber. Procedure: 1. All orders for medications and treatments must be dated and signed by the prescriber and must be current and consistent with the nursing assessment. 2. Content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. 3. Verbal orders received from a prescriber must have the RN/LPN: a. Record and sign the order. b. A record of the verbal order will be kept in	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24668	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	2918 7TH AVENUE NORTH ANOKA, MN 55303

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01760	Continued From page 17 the resident record. c. All verbal orders received will be written and then forwarded to the prescriber for the prescriber's signature. 4. Electronically transmitted orders: a. An order received by facsimile machine, or other electronic means must be received and kept confidential. b. An order received by facsimile machine, or other electronic means must be communicated to a licensed nurse within 1 hour of receipt. c. An order received by electronic means, not including facsimile machine, must be immediately recorded, or placed in the resident's record by a nurse and must be countersigned by the prescriber if not already done so. d. An order received by email or facsimile machine must have been signed by the prescriber and must be immediately recorded or a useable copy must be placed in the resident's record by a person authorized by the RN." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24668	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	2918 7TH AVENUE NORTH ANOKA, MN 55303

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01880	Continued From page 18 medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for one of two residents (R3). 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: R3's signed Service Plan dated May 5, 2023, indicated R3 received assistance with medication administration services, topical medication treatments, dressing, hygiene/grooming, and bathing. On January 29, 2024, at 1:36 p.m., the surveyor observed nystatin powder 100,000 units (u) per gram (g) topical medication unlocked and unsecure in a pink washbasin on R3's bedside tables. On January 29, 2024, at 2:00 p.m., the surveyor inquired if R3 was able to self-administer medication. Licensed practical nurse (LPN)-A stated R3 was not able to self-administer, and medication was kept in the room for staff to administer. Licensed assisted living director (LALD)-C stated they have a doctor's order for R3 to keep the nystatin powder at bedside. LALD-C stated instead of staff going back and forth to get the medication they keep it at the bed side per advice from their consultant.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24668	A. BUILDING: _____ B. WING _____	01/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WILLOWS	2918 7TH AVENUE NORTH ANOKA, MN 55303

(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
01880	Continued From page 19 On January 30, 2024, at 8:00 a.m., LPN-A stated they did not have doctor's order for keeping the nystatin powder at bedside. The licensee's 7.11 Medication Storage policy dated April 4, 2023, indicated medications will be kept securely locked and stored per manufacturer's directions and only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Type: Follow-Up
Date: *02/02/24*
Time: 08:00:00
Report: 1025241019

Food and Beverage Establishment Inspection Report

Location:
The Willows
2918 7th Avenue North
Anoka, MN55303
Anoka County, 02

Establishment Info:
ID #: 0037503
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637128363
ID #:

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

No NEW orders were issued during this inspection.

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

Received email confirmation refrigerator was adjusted and temperature of non TCS (water) in the refrigerator reached < 41 deg F.

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 1025241019 of 02/02/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

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

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

Type: Full
Date: *01/31/24*
Time: 13:00:00
Report: 1025241012

Food and Beverage Establishment Inspection Report

Location:
The Willows
2918 7th Avenue North
Anoka, MN55303
Anoka County, 02

Establishment Info:
ID #: 0037503
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7637128363
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Upstairs refrigerator TCS foods at or above 41 deg F; monitor, adjust, service, etc until TCS foods at or below 41 deg F. Discussed testing and sending follow-up.

Comply By: 01/31/24

Food and Equipment Temperatures

Process/Item: Jam, non TCS
Temperature: 45 Degrees Fahrenheit - Location: Refrigerator door, upstairs
Violation Issued: No

Process/Item: Sour cream
Temperature: 43 Degrees Fahrenheit - Location: Refrigerator, upstairs
Violation Issued: Yes

Process/Item: Butter
Temperature: 40 Degrees Fahrenheit - Location: Downstairs refrigerator, downstairs
Violation Issued: No

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

Food thermometer available
Quat ammonia in use, discussed sanitizers and "Hard Non-porous Food Contact Surface" label instructions
Discussed storage order for residential refrigerators
Dishwasher high temperature test kit available

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher with NSF 184 certification
Facility does not have a 3 compartment sink
Facility does not have a food preparation sink
Facility does not have a stand-alone/dedicated handwashing sink

FACILITY
Kitchen has laminate floor, laminate countertops, wood cabinets, texture ceiling, hollow enclosed cabinet bases, Appliances are residential

Replace the cabinet hardware with stainless handles that are completely smooth (without rigids or indents in the back)
Refrigerator/freezer in laundry room

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

DISHWASHING – NSF 184
Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use this option to sanitize utensils
Provide a means of testing the internal contact temperature of utensil in the dishwasher
If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)
Recommend having an alternative means of sanitizing available case of emergency or service interruption

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

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

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

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)

Type: Full
Date: *01/31/24*
Time: 13:00:00
Report: 1025241012
The Willows

Food and Beverage Establishment Inspection Report

For information, please search "MDH CFPM"

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

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

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

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025241012 of 01/31/24.

Certified Food Protection Manager: Nicole L Aldes

Certification Number: FM107381 Expires: 06/22/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Kathryn S

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

Report #: 1025241012

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 01/31/24
Time In 13:00:00
Time Out

	Address	City/State	Zip Code	Telephone
The Willows	2918 7th Avenue North	Anoka, MN	55303	7637128363

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037503		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) Karen Star **Date:** 01/31/24

Inspector (Signature) Cory King