Electronically Delivered

March 28, 2023

Licensee
The Landmark Of Fridley
6490 Central Avenue Northeast
Fridley, MN 55432

RE: Project Number(s) SL28887015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796
JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28887	A. BUILDING: _____ B. WING _____	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDMARK OF FRIDLEY	6490 CENTRAL AVENUE NE FRIDLEY, MN 55432

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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: SL28887015-0 On February 21, 2023, through February 24, 2023, 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 66 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all sixty six (66) residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 2 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 February 21, 2023, at 11:21 a.m., during review of the licensee's emergency preparedness plan, it was noted that the licensee's emergency preparedness plan lacked the following required content: -current, all-hazards approach facility assessment -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations. -EP training and testing program; -EP training program for staff (including documentation of training provided); -annual EP testing requirements. On February 21, 2023, at 11:50 a.m., registered nurse/regional director (RN/RD)-F confirmed the licensee's emergency preparedness plan lacked all the required content referenced above. On February 22, 2023, at 11:15 a.m., regional director (RD)-E stated generally the executive director, in conjunction with the maintenance director, would complete the required content referenced above, and there is no good reason it was not completed. The licensee's Disaster Planning and Emergency Preparedness policy, dated January 2023, indicated the licensee would have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z.	0 680		

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0 680	Continued From page 3 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 800		

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0 800	Continued From page 4 On a facility tour on March 1, 2023, at approximately 12:00 p.m. with licensed assisted living director (LALD)-C and director of maintenance (DM)-G, it was observed that the top hinge was not installed as originally designed and holes were drilled through the fire-resistant rated door to the laundry room in the memory care unit. Fire resistant rated doors are required to be maintained according to manufactures design. On the same tour a hole in the interior drywall membrane ceiling of the maintenance garage/ shop near the resident garages was observed. The fire-resistant rated floor ceiling assembly of the maintenance garage/shop is required to be maintained as designed. It was observed that the exterior exit path leading through the gated area from the marked exterior exit door in the common living room of the memory care unit was not maintained clear of ice and snow to the public way. Keeping this exterior exit path and the exterior door landings clear of ice and snow helps provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. It was observed a ceiling light was not working in the bathroom of resident room 103. It was also observed a ceiling light was not working in the bathroom of resident room 301. It was also observed multiple sconce lights in the exit stairways were not working. It was also observed the toilet was loose at the connection to the floor in the public restroom on	0 800		

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0 800	Continued From page 5 second floor. These deficient conditions were visually verified by LALD-C and DM-G 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. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 6 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review and interview were conducted on March 1, 2023, at approximately 11:15 a.m. of documents provided by licensed assisted living director (LALD)-C and director of maintenance (DM)-G on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as	0 810		

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0 810	Continued From page 7 follows: Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees in regard to resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and at least once every other month as required. All deficiencies were verified by LALD-C and DM-G during the interview at approximately 11:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as	0 820		

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0 820	Continued From page 8 housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. 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). Findings include: On a facility tour of the memory care unit on March 1, 2023, at approximately 12:00 p.m. with licensed assisted living director (LALD)-C and director of maintenance (DM)-G, it was observed an exterior exit gate from the secure fenced outdoor area was provided with a lock that required a key for egress. At the time of the tour clinical staff did not have a key on them and a key was not available to operate the lock. This	0 820		

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0 820	Continued From page 9 deficient condition was verified by LALD-C and DM-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative;	01060		

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01060	Continued From page 10 (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R2) hospitalized. 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). The findings include: R2 was admitted for services on November 22, 2022, with diagnoses including but not limited to anxiety, Alzheimer's disease, hypertension, acute on chronic hypoxic respiratory failure, right lower lobe infiltrate/pneumonia, tremors, coronary artery disease, chronic kidney disease stage 3, and history of chronic obstructive pulmonary disease. R2's Service Plan effective January 6, 2023,	01060		

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01060	Continued From page 11	01060		

indicated R2 received services including assistance with medication administration, dressing, grooming, toileting assistance, escorts, safety checks, behavior observation, and intake monitoring.

R2's discharge summary dated January 12, 2023, at 4:37 p.m., indicated R2 was admitted to the hospital on January 9, 2023, for right lower lobe infiltrate/pneumonia.

R2's discharge summary dated January 12, 2023, at 4:37 p.m., indicated R2 was re-admitted to the assisted living with dementia care facility on January 12, 2023.

R2's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum:
- the reason for the relocation;
- the name and contact information for the location to which the resident had been relocated and any new service provider;
- contact information for the Office of Ombudsman for Long-Term Care (OOLTC);
- if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and
- a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal.

On February 21, 2023, at 1:35 p.m., registered nurse (RN)-A stated they were unaware the facility needed to provide a written notice with the required content for an emergency relocation to

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01060	Continued From page 12 the resident, the residents' legal representative, and designated representative, as required, unless resident had been relocated for more than four days. The licensee's Emergency Relocation policy, effective January 2023, indicated the facility may remove a resident from the facility in an emergency if necessary due to the resident's urgent medical needs or an imminent risk the resident posed to the health or safety of another facility resident or staff member, and in the event of an emergency relocation, would provide a written notice that contained the above required content. The notice would be delivered as soon as practicable to the resident, legal representative, and designated representative, and the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever	01610		

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	28887	A. BUILDING: _____ B. WING _____	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDMARK OF FRIDLEY	6490 CENTRAL AVENUE NE FRIDLEY, MN 55432

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01610	Continued From page 13 is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a pre-admission comprehensive assessment to cover all parts of the uniform assessment tool for two of two residents (R3, R5). 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: R3 started receiving services from the licensee on November 22, 2022. R3's record included a pre-admission assessment Level of Care Tool, Brief Interview for Mental Status (BIMS) Tool and a Medication/Treatment Individual Management Plan Tool all dated November 9, 2022. R5 started receiving services from the licensee on January 18, 2023.	01610		

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01610	Continued From page 14 R5's record included a pre-admission assessment Level of Care Tool and BIMS Tool both dated January 12, 2023. R3 and R5's assessments lacked required parts of the uniform assessment tool to include: - the resident's personal lifestyle preferences, including: sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; spiritual and cultural preferences; and advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order; - instrumental activities of daily living, including: housework and laundry; and transportation; - physical health status: a review of relevant health history and current health conditions, including medical and nursing diagnoses; allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening, infectious conditions; a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months, weight; and initial vital signs if indicated by health conditions or medications; - emotional and mental health conditions; - communication and sensory capabilities; - pain;	01610		

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01610	Continued From page 15 - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; - risk indicators; and - who has decision-making authority for the resident. On February 15, 2023, at 10:15 a.m., RN/regional director (RN/RD)-F, stated the licensee's preassessment covers all the required uniform assessment tool sections. RN/RD-F also stated the same assessment tool was used for all the licensee's new residents. The licensee's Comprehensive Assessment Schedule guideline dated August 2022, indicated the RN will complete an individualized preassessment and complete client monitoring and reassessment within 14 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 16 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. 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 ongoing resident assessment monitoring no more than 14 days after start of services for one of five 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) 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 record included a level of care Brief Interview for Mental Status (BIMS), and medication and treatment management plan assessment dated November 9, 2022, and a new	01620		

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01620	Continued From page 17 nursing assessment dated December 12, 2022, which exceeded 14 calendar days from the start of services by 16 days. On February 23, 2023, at 12:19 p.m., RN-A stated R3's 14 day assessment exceeded 14 days from the resident admission date. RN-A stated the assessment was not done timely and she did not have a reason for it. The licensee's Comprehensive Assessment Schedule tool dated January 2023, indicated ongoing client monitoring and reassessment must be conducted within 14 days after the initiation of services and at least every 90 days from the last date of assessment, and when the resident presents with symptoms or other issues that may be medication related, and as indicated for changes in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01880 SS=F	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 medications were stored according to the manufacturer's recommended temperature.	01880		

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01880	Continued From page 18 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 February 22, 2023, at 2:15 p.m. the surveyor reviewed the medication refrigerator located in the locked nursing office with regional registered nurse (RN)-D. The temperature of the refrigerator was observed to be 38 degrees Fahrenheit (F). Surveyor reviewed the current refrigerator temperature log (no identifying month written on current log) that indicated seventeen times temperatures were logged, with 6 times being out of manufactures recommended range and nothing was noted regarding changes or follow up. RN-D stated temperature logs were supposed to be done twice daily. Twenty-three (23) days in February had not been recorded, dates were left blank. RN-D indicated that after morning and evening narcotic count the temperature of the refrigerator was expected to be recorded by the nurse. RN-D confirmed the log was missing recorded dates and confirmed there were temperatures logged outside of the safety range with no follow up. On February 22, 2023 at 3:52 p.m. RN-A confirmed the medication refrigerator contents were 8 Basaglar pens, 9 Novlog Flexpens, 5 Novolog 70/30 Flexpens, 2 Trulicity pens, 1 Victoza Flexpen, 2 Humalog Kwik Flexpens, 5 Lantus Solo Flexpens, 1 bottle of Brimonidine	01880		

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01880	Continued From page 19 Solution 0.15% eye drops, and 1 bottle of Dorzolamide Timolol Solution 22.3-6.8 eye drop. On February 23, 2023, at 1:00 p.m. RN-A stated all medication that is recommended to be stored in the refrigerator is kept unopened in the fridge until use per manufacturer's recommendation. The refrigerator is monitored daily and logged to know the temperature daily, anything outside the range is to be reported for follow up or changes. The Federal Drug Agency's (FDA) Information Regarding Insulin Storage and Switching Between Products in an Emergency website article retrieved March 1,2023 at 1:49 p.m., read, "According to the product labels from all three U.S. insulin manufacturers, it is recommended that insulin be stored in a refrigerator at approximately 36 degrees Fahrenheit (°F) to 46°F. Insulin products contained in vials or cartridges supplied by the manufacturers (opened or unopened) may be left unrefrigerated at a temperature between 59°F and 86°F for up to 28 days and continue to work." Drug label recommendation for storage of Dorzolamide Hydrochloride and Timolol Maleate eye drops and Brimonidine Tartrate Ophthalmic Solution are both recommended to be stored at room temperature 68 to 77 degrees Fahrenheit per websites recommendations retrieved March 1, 2023. The licensee's March 2021, Medication & Treatment policy, indicated medications shall be stored consistent with the manufacturer's recommendations. Policy indicated the expiration date of a product can be changed once it is opened. The policy further indicated that insulin unopened will be stored in the refrigerator until	01880		

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01880	Continued From page 20 opened. No further information was provided. TIME PERIOD FOR CORRECTION- Seven (7) days	01880		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to	02110		

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02110	Continued From page 21 and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and designated representatives at the time of move in for five of five residents (R1, R2, R3, R4, R5). 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: R1 was admitted to the licensee November 10, 2020 and started receiving assisted living services August 1, 2021. R2 was admitted to the licensee November 8, 2021. R3 was admitted to the licensee for assisted living services on November 22, 2022. R4 was admitted to the licensee June 5, 2018 and started receiving assisted living services	02110		

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02110	Continued From page 22 August 1, 2021. R5 was admitted to the licensee January 18, 2023. R1, R2, R3, R4, and R5's resident records lacked evidence a resident or resident representative received and acknowledged the written dementia policies and procedures that addressed 144G.82 Subd. 3. at the time of move-in to the licensee. On February 23, 2023, at 12:16 p.m., registered nurse (RN)-A sent through email a document called Special Care Status Disclosure for Memory Care Support Community, and indicated the document was the required dementia policies. The document lacked the required ten (10) assisted living with dementia care additional policies. On February 23, 2023, at 12:35 a.m., RN/regional director (RN/RD)-F stated licensee provided residents and resident representatives with a Special Care Status Disclosure for Memory Care Support Community document at admission and was also available online for residents upon signing on to the portal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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

Type: Full
Date: *02/21/23*
Time: 12:00:00
Report: 1025231042

Food and Beverage Establishment Inspection Report

Location:
The Landmark Of Fridley
6490 Central Avenue Ne
Fridley, MN55432
Anoka County, 02

Establishment Info:
ID #: 0038590
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635717355
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

Visited establishment.

Spoke with Sandy with Cura.

Foodservice at location is under contract. Discussed licensing with Anoka County.

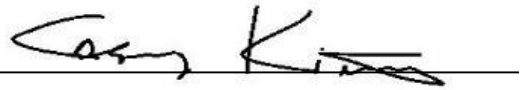
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025231042 of 02/21/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: 

Casey Kipping
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