DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 6, 2022

Administrator
Gemini Manor
20752 Gemini Trail
Lakeville, MN 55044

RE: Project Number(s) SL30432015

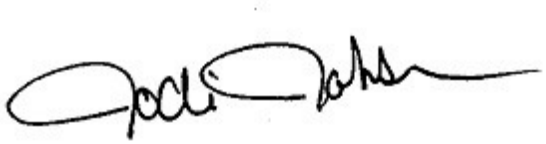
Dear Administrator:

On September 16, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 23, 2022, evaluation were corrected. This 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,



Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

Electronically Delivered

July 25, 2022

Administrator
Gemini Manor
20752 Gemini Trail
Lakeville, MN 55044

RE: Project Number(s) SL30432015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 23, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 . . ."

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), 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 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. 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.

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,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30432	A. BUILDING: _____ B. WING _____	06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GEMINI MANOR	20752 GEMINI TRAIL LAKEVILLE, MN 55044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30432015 On June 21, 2022, through June 23, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six residents, all of whom received services under the provider's Assisted Living license. On June 23, 2022, at immediate order was issued for Tag 0820 at a level 3/widespread scope (I).	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.	
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) with the required content for one of one resident (R1) with records reviewed. This practice resulted in a level one violation (a violation that has not 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 the potential to affect a large portion or all the residents).	0 430		

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0 430	Continued From page 2 The findings include: R1 started receiving services on January 24, 2022, for dementia and hypertension. On June 21, 2022, at 1:35 p.m. the surveyor observed unlicensed personnel (ULP)-B passing medication to R1. R1's record lacked evidence of a signed copy of the UDALSA. On June 21, 2022, at 1:46 p.m. registered nurse (RN)-A confirmed R1's file did not contain a contract or UDALSA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
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 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	0 480		

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0 480	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, chapter 4626. This had the potential to affect all 6 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 21, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) 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 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	0 485		

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0 485	Continued From page 4 fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all six residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 surveyor did not observe a posting of the menu in the facility. On June 22, 2022, at 1:26 p.m. unlicensed personnel (ULP)-B confirmed tonight's menu would be an Oncor TV dinner with mashed potatoes. When asked about what fruit and	0 485		

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0 485	Continued From page 5 vegetables would be served, ULP-B indicated they were having Jello with the TV dinner. On June 22, 2022, at 1:00 p.m. registered nurse (RN)-A confirmed they did not display a posting of the menu, but indicated they would provide a copy from the licensed assisted living director (LALD). On June 22, 2022, at 1:40 p.m. LALD-F provided a copy of the weekly menu via email. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental,	0 490		

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0 490	Continued From page 6 and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all six residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The surveyor did not observe a posting of activities offered, or any activities being provided during the survey. On June 21, 2022, during the entrance conference, registered nurse (RN)-A stated they did not offer daily programs of social and recreational activity; however, sometimes they watched a movie together. The licensee's assisted living resident contract template dated May 31, 2021, indicated social activities, wellness, and educational programs as scheduled would be provided in the monthly fee.	0 490		

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0 490	Continued From page 7 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report incidents of neglect of supervision to the Minnesota Adult Abuse Reporting Center (MAARC), for one of two residents (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 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: A review of incident reports indicated R5 had	0 620		

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0 620	Continued From page 8 eloped on May 27, 2022, around 9:45 p.m. There was no evidence of a report made to MAARC for this incident. The incident report indicated R5 unlocked the front door and walked out of the house while the unlicensed personnel (ULP) was tending to another resident. 911 was called and police found the resident and brought him back to the facility. On June 21, 2022, at approximately 1:07 p.m. registered nurse (RN)-A confirmed a MAARC should have been created for an elopement, and stated they were unfamiliar the requirements of a report. The licensee's undated, Client at Risk of Wandering and/or Elopement policy indicated the RN will report an incident to the common entry point within 24 hours of an elopement. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes	0 630		

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0 630	Continued From page 9 self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) that included an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults for one of one resident (R1) with 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: R1 started receiving services on January 24, 2022, for dementia and hypertension. On June 21, 2022, at 1:35 p.m. the surveyor observed unlicensed personnel (ULP)-B passing medication to R1. R1's record lacked evidence of an IAPP. R1's initial assessment indicated continuous displays of depression, anxiousness and impaired judgement and occasional displays of wandering, aggressive behavior, danger to self/others, agitation, disturbed sleep, resistive to cares,	0 630		

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0 630	Continued From page 10 unsafe behavior, and paranoia. On June 21, 2022, at 1:46 p.m. registered nurse (RN)-A stated if there was not an IAPP in the file, then they did not have one. The licensee's undated, Abuse Prevention policy indicated that all residents admitted to the facility will be assessed for abuse and will be incorporated into their care plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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 interview and record review, the	0 660		

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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
0 660	Continued From page 11	0 660		

licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-B) 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:

The licensee's TB facility risk assessment dated May 13, 2022, indicated they were a low risk level.

ULP-B started working for licensee on November 10, 2021, to provide direct care to the residents.

On June 21, 2022, at 1:35 p.m. the surveyor observed ULP-B pass medication to R1.

ULP-B's record lacked evidence of TB testing via two-step TST or a blood test.

On June 21, 2022, at 2:38 p.m. ULP-B confirmed she had not completed TB testing.

On June 21, 2022, at 3:09 p.m. registered nurse (RN)-A confirmed a TB test had not been

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0 660	Continued From page 12 completed yet. The licensee's undated, Tuberculosis Screening policy indicated TB screening and testing would be completed before resident contact. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 tenant 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	0 680		

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0 680	Continued From page 13 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include the Appendix Z required content. This had the potential to 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). The findings include: The licensee's emergency preparedness plan consisted of a blank template. On June 22, 2022, at 2:15 p.m. registered nurse (RN)-A confirmed the emergency management policies fields were blank. The licensee's undated, Emergency Management policy identified fields to customize, which were left blank. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780	Continued From page 14	0 780		
0 780 SS=F	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 licensee failed to provide the required smoke alarm in the main floor resident room #4 and a working smoke alarm for the main hallway within the vicinity of the resident rooms. This has the potential to directly affect all occupied residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 780		

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0 780	Continued From page 15 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 June 23, 2022, approximately from 10:15 a.m. to 11:40 a.m., survey staff toured the home with the owner (O2)-D. During the tour on smoke alarm requirements, survey staff observed the following findings: 1) Main floor resident room # 4 (labeled as an office on the home's floor plan layout) was not provided with a smoke alarm as required. Survey staff questioned if the room was used as an office and converted into a resident room since it was the only room with no smoke alarm. The O2-D confirmed that the room was one time used as an office. The O2-D verified the finding. 2) The smoke alarm located outside the hallway within the vicinity of bedrooms next to resident room #3 was not working correctly when tested. Survey staff and the O2-D observed the smoke alarm chirping and failed to sound other smoke alarms in the home when tested. The O2-D verified the finding. 3) The smoke alarm in the lower level (unfinished basement) was not maintained as required to ensure the smoke alarm did not exceed 10 years from the date of manufacture. Survey staff observed that the label on the back of the unit had a manufactured date stamped with the year 2006. Survey staff explained that if all smoke alarms were the original alarms installed at the	0 780		

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0 780	Continued From page 16 time of construction (2008-2009), they must be replaced when they exceed 10 years from the date of manufacture. The O2-D and the patient care assistant- E verified the finding. The O2-D stated that she will replace all the smoke alarms. On June 23, 2022, at approximately 1:35 p.m., during the exit interview, the O2-D acknowledged the findings. Survey staff explained to the O2-D that the missing smoke alarms in resident room #4 and in the main hallway also must all be interconnected with the home smoke alarm system such that when any one smoke alarm is activated and sounds, causes all smoke alarms in the home to sound for notification. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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 Code; and This MN Requirement is not met as evidenced by:	0 790		

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0 790	Continued From page 17 Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all 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 June 23, 2022, approximately from 10:15 a.m. to 11:40 a.m., survey staff toured the home with the owner (O2)-D. During the tour, survey staff observed and the O2-D verified that the portable fire extinguishers were tagged showing the annual service date of February 2022, but lacked records to show the required monthly visual inspections were performed and recorded for the portable fire extinguishers located on the upper- and lower-level floors of the home. On June 23, 2022, at approximately 1:35 p.m., during the exit interview, the O2-D acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800	Continued From page 18	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 on 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 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, 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 are: On June 23, 2022, approximately from 10:15 a.m. to 11:40 a.m., survey staff toured the home with the owner (O2)-D. During the tour survey staff observed and the O2-D verified the following findings: 1) No carbon monoxide detectors were installed in the home to maintain a safe living environment.	0 800		

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0 800	Continued From page 19 This was evident as the O2-D and survey staff toured the home seeking carbon monoxide detectors. The O2-D stated that she thought they installed the combination smoke alarm and carbon monoxide detectors in the home. Further investigation by the patient care assistant-E, the label on the back of the unit indicated, "multi-station smoke alarms", and no carbon monoxide detection. 2) Cleaning chemicals such as bleach and CLEAR brand chemical were stored under the bathroom cabinet and the cabinet doors were not restricted and secured from resident access for safety. The O2-D relocated the chemical during the survey. The O2-D verified the finding. 3) Multiple extension cords were near used in the mechanical area of the unfinished basement which posed a potential electrical fire hazard from overloading the electrical circuits. 4) The exhaust fan for the employee use bathroom was heavily layered with dust. 5) The furnace filter was heavily layered with dust. This finding was evident as the filter was removed for observation. She asked her employee, patient care assistant-E, to replace the filter during the tour. 6) The air conditioning located outside next to the window well was heavily layered with cottonwood and debris. On June 23, 2022, at approximately 1:35 p.m., during the exit interview, the O2-D acknowledged the findings. No further information was provided.	0 800		

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0 800	Continued From page 20 TIME PERIOD FOR CORRECTION: Fourteen (14) 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 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the required fire safety and evacuation plan, required training, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 23, 2022, at approximately 11:45 a.m., survey staff asked for the home's fire safety and evacuation documentation, the evacuation drill, and the training documentation from the owner (O2-D) for review. FIRE SAFETY AND EVACUATION PLAN 1) Evacuation and fire safety plan documentation was not available for review and therefore, was not readily available within the facility. The O2-D asked survey staff for details of what the plan would entail and then proceeded to explain that her sister (business partner) was currently working on the development of the plan. 2) The evacuation plan lacked the following elements: - Employee actions to be taken in an event of a	0 810		

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fire or similar emergency.
- Specific procedures for addressing all resident movement, evacuation, or relocation during a fire or similar emergency including any unique resident-specific situations during an evacuation such as residents who are wheelchair-bound, on walkers, bedridden, and needing assistance during an evacuation.
- Fire protection procedures for residents.
- The posted floor plan layout incorrectly showed a resident room as an office when the room is bedroom #4.
- The floor plan incorrectly identified exits to the garage and to the deck with a gate that was secured with a cable and a padlock. The O2-D explained that she can remove the lock from the gate.

EVACUATION DRILLS
The review of the facility's documented drill record indicated licensee failed to show compliance with the minimum number of required employee fire and evacuation drills performed to date for a minimum of two drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. The drill records showed the drills performed were based on the quarterly frequency with dates recorded, March 17, 2022, and June 6, 2022. The O2-D explained that there may be other records available prior to March 17, 2022. Survey staff explained the dates for their employee drills were not in compliance with the minimum of every other month and appeared to be quarterly. Survey staff advised the O2-D to vary drill times for their two employee shifts and to maintain those records on-site and readily available.

TRAINING
1) No documents or records were provided on the

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0 810	Continued From page 23 employee training on fire safety and evacuation. Survey staff explained that fire safety and evacuation training is specifically required at minimum upon hire and twice a year. The policy and record documentation must be reflected as such. 2) The documentation lacked the policy of the training of residents that can self-assist in their evacuation on the proper actions to be taken in the event of a fire including movement, evacuation, or relocation, required annually. On June 23, 2022, at approximately 1:35 p.m., during the exit interview, the O2-D acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as 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.	0 820		

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0 820	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all physical facility elements, including, the minimum size egress window opening for occupied resident bedroom #4, and the front entrance door hardware, do not create a distinct hazard to residents and staff. This affected all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 23, 2022, at approximately from 10:15 p.m. to 11:40 p.m., survey staff toured the home with the owner (O2)-D. At approximately, 10:25 a.m., survey staff observed a deadbolt lock on the front entrance door that required a key to exit the home. Survey staff also observed that the door had two security slide-locks, one located at the top and one at the bottom of the door. Survey staff asked the O2-D about the locks on the front door. The O2-D explained that they have one resident that is likely to elope once or twice a month. She also explained that they installed the deadbolt about two weeks ago. Survey staff explained the deadbolt lock and the security slide-locks restrict and delay the home's primary mean of egress during a fire or similar emergency.	0 820		

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0 820	Continued From page 25 At approximately, 11:10 a.m., survey staff measured the windows in bedroom #4 (labeled as an office on the home floor plan) on the main level and explained to the O2-D that the windows in the bedroom #4 did not meet the minimum size egress window opening required for safe egress. At least one window in the bedroom must meet the state standard minimum existing window opening size of at least 20 inches in width (and a minimum height of 20 inches) with a total of at least 648 square inches (4.5 square feet) required for egress window openings for bedrooms for assisted living facilities. The egress window opening dimensions in bedroom #4 were measured with width of 15.75 inches and height of 55.5 inches. Survey staff asked if the room was one time used an office and converted into a resident room since it was the only room with no smoke alarm and different window design than other bedrooms. The O2-D agreed that that the room was one time an office. The O2-D confirmed the finding. On June 23, 2022, at approximately 12:25 p.m., survey staff explained to the O2-D that an immediate correction is issued for the above findings. The O2-D acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.	0 900		

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0 900	Continued From page 26 (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of one resident (R1) with record reviewed.	0 900		

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0 900	Continued From page 27 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 started receiving services on January 24, 2022, for dementia and hypertension. On June 21, 2022, at 1:35 p.m. the surveyor observed unlicensed personnel (ULP)-B pass medication to R1. A review of R1's file lacked evidence of a contract. On June 21, 2022, at 1:46 p.m. registered nurse (RN)-A confirmed R1's file did not contain a contract. The licensee's undated, Assisted Living Contract policy indicated the contract must be maintained by the facility and available at any time for inspection. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01470 SS=D	144G.63 Subd. 2 Content of required orientation	01470		

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01470	Continued From page 28 (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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	01470		

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01470	Continued From page 29 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 the challenges it poses to communication; (2) 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 observation, interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-B) received orientation to assisted living facility licensing requirements and regulations before providing services 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: ULP-B had a hire date of November 10, 2021.	01470		

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01470	Continued From page 30 On June 21, 2022, at 9:30 a.m. ULP-B was observed to administer medication to R1. A review of ULP-B's record lacked evidence of the following orientation requirements: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person On June 21, 2022, at approximately 3:09 p.m. registered nurse (RN)-A confirmed that the above training requirement was missing from ULP-B's file. The licensee's undated, policy on facility employee orientation indicated that completion of the orientation training shall be documented in the employee's file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee lacked current written or electronically recorded prescriptions for one of one resident (R1) with records reviewed.	01820		

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01820	Continued From page 31 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 was started receiving services at the facility on January 24, 2022, for dementia and hypertension. On June 21, 2022, at approximately 1:35 p.m. unlicensed personnel (ULP)-B administered medication to R1. R1's medication administration record noted medication administration for Amlodipine 2.5 milligrams (mg) (reduce blood pressure), Lisinopril 10 mg (reduce blood pressure), and Metformin 500 mg (for diabetes). R1's file lacked evidence of current written or electronically recorded prescriptions. On June 21, 2022, at 2:19 p.m. registered nurse (RN)-A requested a list of R1's medications from the pharmacy. RN-A further confirmed R1's record laced a written or electronic prescription for all medications administered. The licensee's undated, Medication Administration policy indicated the licensee will obtain current prescriber orders on file for all medications managed. No further information provided.	01820		

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01820	Continued From page 32 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
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 prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to 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 include: On June 21, 2022, at 9:24 a.m. the surveyor noted the locking mechanism for the medication cabinet was a magnet that was easily unlocked by a magnetic disk on the side of the microwave, directly outside the locked cabinet and could	01880		

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01880	Continued From page 33 easily be unlocked by anyone in the kitchen. On June 21, 2022, at approximately 10:00 a.m. during the entrance conference, registered nurse (RN)-A observed the unlocked medication cabinet and confirmed the medication cabinet should always be locked. The licensee's undated, Medication Management Services policy noted medications were to be kept securely locked. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other	01910		

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01910	Continued From page 34 individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable for one of one discharged resident (R2) with 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) 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: R2 was discharged from the licensee on February 4, 2022. R2's medication disposal form lacked fields to include the medication prescription (Rx) number, as applicable. On June 21, 2022, at approximately 1:20 p.m. registered nurse (RN)-A confirmed the medication disposition form for R2 did not include a place for Rx numbers to be included, and was unaware that was a requirement. The facility's undated, Medication Disposition or Disposal policy dated August 1, 2021, noted staff will document in the resident's record, listing the time, date, drug name, dose and quantity.	01910		

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01910	Continued From page 35 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02240 SS=D	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and	02240		

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02240	Continued From page 36 Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure the current "Minnesota Bill of Rights for Assisted Living Residents" was provided to the resident and a written acknowledgement received for one of one resident (R1) with 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) 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 began receiving assisted living services from the licensee January 24, 2022. On June 21, 2022, at approximately 1:35 p.m. unlicensed personnel (ULP)-B administered medication to R1.	02240		

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02240	Continued From page 37 R1's record lacked a copy and acknowledgement of receiving the Assisted Living bill of rights The licensee's undated, Assisted Living Bill of Rights policy indicated the licensee will review the form and ask the resident or their representative to sign indicating they have been informed of their rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as	03000		

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03000	Continued From page 38 described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to report incidents of neglect of supervision to the Minnesota Adult Abuse Reporting Center (MAARC), for one of two residents (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 an isolated scope (when one or a limited number of	03000		

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03000	Continued From page 39	03000		

residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

A review of incident reports indicated R5 had eloped on May 27, 2022, around 9:45 p.m. There was no evidence of a report made to MAARC for this incident.

The incident report indicated R5 unlocked the front door and walked out of the house while the unlicensed personnel (ULP) was tending to another resident. 911 was called and police found the resident and brought him back to the facility.

On June 21, 2022, at approximately 1:07 p.m. registered nurse (RN)-A confirmed a MAARC should have been created for an elopement, and stated they were unfamiliar the requirements of a report.

On June 27, 2022, at 9:09 a.m. surveyor created the required MAARC form.

The licensee's undated client at risk of wandering and/or elopement policy indicated the RN will report an incident to the common entry point within 24 hours of an elopement.

No further information was provided.

TIME PERIOD TO CORRECT: Seven (7) days.

Minnesota Department of Health
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Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/21/22*
Time: 10:30:00
Report: 1005221055

Food and Beverage Establishment Inspection Report

Location:
Gemini Manor
20752 Gemini Trail
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0038475
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9529856495
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.

3-200A Food Characteristics: approved source

3-201.11B ** Priority 1 **

MN Rule 4626.0130B Remove all foods that were prepared or stored in a private home from the premises, except as allowed in Minnesota Statutes 28A.15 and 157.22 clauses 6 and 7.

LUNCHES ARE PREPARED IN AN UNLICENSED, RESIDENTIAL KITCHEN AND DELIVERED TO THE FACILITY. DISCONTINUE THIS IMMEDIATELY. ALL FOOD MUST BE PREPARED ON SITE BY STAFF, OR COME FROM A LICENSED FACILITY.

Comply By: 06/21/22

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

THE DISHWASHER WAS PROVIDING A UTENSIL SURFACE TEMPERATURE OF LESS THAN 150 DEGREES F. REPAIR OR REPLACE DISHWASHER.

Comply By: 06/21/22

3-500C Microbial Control: date marking

3-501.17A ** Priority 2 **

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

NO DATE-MARKING WAS OBSERVED. DISCUSSED MARKING THE DATE THAT FOODS

WERE OPENED OR PREPARED TO ENSURE THEY ARE USED OR DISCARDED WITHIN SEVEN DAYS. FACT SHEET LEFT ON SITE.

Comply By: 06/21/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

NO REGISTERING THERMOMETER OR TEMPERATURE SENSITIVE STRIPS WERE AVAILABLE FOR THE DISHWASHER. INSPECTOR LEFT STRIPS ON SITE FOR STAFF TO VERIFY THAT DISHWASHER IS SANITIZING.

Comply By: 06/28/22

2-100 Supervision

2-102.12AMN

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

THE EMPLOYEE NAME THAT WAS PROVIDED AS THE CFPM IS NOT A FULL-TIME EMPLOYEE. THE CFPM MUST BE AN EMPLOYEE THAT IS AT THE FACILITY REGULARLY AND CAN OVERSEE FOOD SAFETY POLICIES AND PROCEDURES. SEE COMMENTS.

Comply By: 07/23/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETER WAS PRESENT IN THE REFRIGERATOR.

Comply By: 06/28/22

Food and Equipment Temperatures

Process/Item: Cold Hold/SOUP
Temperature: 31 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/OATMEAL
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/PORK
Temperature: 34 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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Process/Item: Cold Hold/HOT DOG
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: Hot Hold/CHICKEN
Temperature: 184 Degrees Fahrenheit - Location: OVEN
Violation Issued: No

Process/Item: Hot Hold/RICE
Temperature: 151 Degrees Fahrenheit - Location: OVEN
Violation Issued: No

Process/Item: Hot Hold/VEGGIES
Temperature: 152 Degrees Fahrenheit - Location: OVEN
Violation Issued: No

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

INSPECTION COMPLETED WITH OWNER CHRISTINE RAMUARAIN AND REVIEWED WITH HRD EVALUATOR TRACEY FEARON.

THERMOLABELS WERE LEFT ON SITE SO FACILITY COULD CHECK THE UTENSIL SURFACE TEMPERATURE BEING PROVIDED BY THEIR DISHWASHER. A PICTURE WAS SENT TO INSPECTOR AFTER THE INSPECTION, WHICH SHOWED THAT THE TEMPERATURE WAS LESS THAN 150 DEGREES F.

THE DISHWASHER MUST BE ADJUSTED, REPAIRED, OR REPLACED SO DISHES ARE REACHING AT LEAST 160 DEGREES F TO BE SANITIZED.

EMPLOYEE STATED THAT LUNCHES ARE PROVIDED BY AN INDIVIDUAL OUT OF A RESIDENTIAL HOME. THIS MUST BE DISCONTINUED IMMEDIATELY. ALL FOOD MUST BE PREPARED ON SITE, OR COME FROM A LICENSED KITCHEN.

ESTABLISHMENT MUST HAVE A MN CERTIFIED FOOD PROTECTION MANAGER (CFPM) THAT IS REGULARLY AT THE FACILITY AND CAN OVERSEE FOOD SAFETY POLICIES AND PROCEDURES. THERE IS A LACK OF OVERSIGHT AND POLICIES TO PREVENT FOODBORNE ILLNESS, AS EVIDENCED BY THE LACK OF SANITIZING, DATE-MARKING, AND PROVIDING FOOD FROM AN APPROVED SOURCE.

ALSO DISCUSSED EMPLOYEE ILLNESS, BARE HAND CONTACT, DATE MARKING, AND COOKING TEMPERATURES.

FACILITY HAS POPCORN CEILINGS AND HOLLOW, ENCLOSED BASES FOR THE CABINETS. NEITHER OF THESE ARE APPROVED, BUT ARE CLEAN AND IN GOOD REPAIR AT THIS TIME. CEILING AND CABINETS WILL BE MONITORED AT FUTURE INSPECTIONS.

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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 1005221055 of 06/21/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
CHRISTINE RAMUARAIN
OWNER

Signed:_____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us