Electronically Delivered

January 4, 2023

Licensee
Shorewood Commons
2115 2nd Street Southwest
Rochester, MN 55902

RE: Project Number(s) SL20686015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 20, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

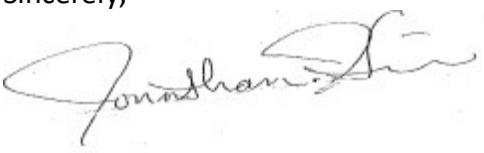
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 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
	20686	A. BUILDING: _____ B. WING _____	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOREWOOD COMMONS	2115 2ND STREET SW ROCHESTER, MN 55902

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING 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: SL20686015-0 On December 19, 2022, through December 20, 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 seventy seven (77) residents, all of whom received services under the provider's Assisted Living with Dementia Care license. On February 9, 2023, an error was identified for licensing order 0480; the order was rescinded and a new State form was sent to the provider.	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 with Dementia Care 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 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 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all seventy-seven (77) 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	0 680		

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0 680	Continued From page 2 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 December 19, 2022, licensee's emergency preparedness plan lacked the following required content: - must establish/maintain a comprehensive emergency preparedness plan which describes described the facility's approach to meeting health/safety/security needs of staff/residents that would be reviewed/updated annually. -process for emergency preparedness cooperation with state and local emergency preparedness officials/organizations. -emergency preparedness training program for staff (including documentation of training provided). -annual emergency preparedness testing requirements. On December 19, 2022, at 3:50 p.m., executive director (ED)-A confirmed licensee's emergency preparedness plan lacked the required content above, and licensee had not participated in an annual full-scale exercise that was community based, or conducted an annual, individual, facility-based functional exercise. The licensee's Disaster Planning and Emergency Preparedness policy, dated August 1, 2021, indicated the licensee's intent would be to have in place an effective and compliant Emergency Preparedness Plan that would be in alignment with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z. Furthermore, the licensee's emergency	0 680		

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0 680	Continued From page 3 preparedness plan would include all the required elements of appendix Z, be in writing, and reviewed annually. 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 staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 800		

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0 800	Continued From page 4 Findings include: 1. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed during the tour of the facility that in RM 309, markings on the side of the smoke alarm indicated that the device was installed 07/30/2021 2. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed during the tour of the facility that the trash cute doors located on the 3rd and 2nd Floors did not properly close and seal the vertical shaft 3. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed during the tour of the facility that in RM 202 there was a 1-to-3 multi-tap adapter connected to an extension cord 4. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed during the tour of the facility that in RM 215 there was an extension cord in use 5. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed during the tour of the facility that on the 1st FL all smoke / fire door assemblies in the main corridors exhibited issues of not being able to self-close and seal properly 6. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed during the tour of the facility that in Activities Room, the exit door had no identifying signage 7. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed during the tour of the facility that in the Kitchen an extension cord was powering a high current device (commercial refrigerator)	0 800		

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0 800	Continued From page 5 8. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed during the tour of the facility that in the Kitchen / Dishwashing Areas, sprinkler heads were laden with foreign debris and were exhibiting signs of potential oxidation 9. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed during the tour of the facility that in the Recycling Corridor, recycling bins were restricting access to the manual fire alarm pull-station MD-C verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (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	0 810		

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0 810	Continued From page 6 plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: 1. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed that no documentation was presented during documentation review to	0 810		

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0 810	Continued From page 7 confirm that fire drills are occurring 2. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed that no documentation was presented during documentation review to confirm that staff are receiving initial fire and evacuation training upon hire and twice per year annual training 3. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed that no documentation was presented during documentation review to confirm that residents of the facility are being offered annual training of evacuation procedures 4. On 12/19/2022 between 11:30 AM TO 02:30 PM, survey staff observed that no documentation was presented during documentation review to confirm that evacuation drills are being conducted MD-C verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

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01620	Continued From page 8	01620		

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 a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initial assessment, and not to exceed 90 calendar days from the previous assessment for two of five residents (R2, R4).

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 December 20, 2021, and received services including assistance with medication administration, activities of daily living (ADLs), toileting, housekeeping, and laundry.

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01620	Continued From page 9 R2's record included an admission assessment completed December 20, 2021, and a 14-day reassessment completed January 17, 2022, which was 14 days after the reassessment was due. R4 was admitted March 10, 2022, and received services including assistance with medication administration, ADLs, housekeeping, and laundry. R4's record included a change of condition reassessment dated August 29, 2022, and a 90-day reassessment dated November 29, 2022, which was 3 days after the 90-day assessment was due. On December 20, 2022, at 12:40 p.m., registered nurse (RN)-B stated the 14-day assessment for R2 was completed on time, but was entered into the electronic record on the date shown. On December 20, 2022, at 3:05 p.m., RN-B stated R4's assessment was documented as completed on the date shown. RN-B stated possibly the nurse completed it on time, and entered it into the electronic record on the date shown, but had no documentation of that. RN-B further stated possibly the nurse completing the assessment was busy and missed the due date. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated, "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."	01620		

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01620	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

DEPARTMENT OF HEALTH

Type: Full
Date: *12/20/22*
Time: 11:58:59
Report: 7920221269

Food and Beverage Establishment Inspection Report

Location:
Shorewood Commons
2115 2nd Street Sw
Rochester, MN55902
Olmsted County, 55

Establishment Info:
ID #: 0037575
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072529110
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.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.14A

MN Rule 4626.1530A Maintain clean all intake and exhaust air ducts and change filters so they are not a source of contamination.

Clean the ceiling vents of the accumulated dust.

Comply By: 12/20/22

Surface and Equipment Sanitizers

Hot Water: = at Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Freezer
Temperature: -1-` Degrees Fahrenheit - Location: Meats, Fries, vegetables, cooling
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 41 Degrees Fahrenheit - Location: Fruit, vegetables, eggs, meats, piesa, milk
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 38 Degrees Fahrenheit - Location: Fruit, sausage,
Violation Issued: No

Type: Full
Date: *12/20/22*
Time: 11:58:59
Report: 7920221269
Shorewood Commons

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: -8 Degrees Fahrenheit - Location: Ice cream
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -7 Degrees Fahrenheit - Location: Breads
Violation Issued: No

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

I acknowledge receipt of the inspection report number 7920221269 of 12/20/22.

Certified Food Protection Manager: Timothy D Wilcken

Certification Number: FM9139 Expires: 09/07/25

Signed: _____
Establishment Representative

Signed: _____
Sam Boysen
Public Health Sanitarian
Rochester District Office
507-206-2719
samuel.boysen@state.mn.us