Electronically Delivered

August 6, 2025

Licensee
Harbor Crossing
4650 Centerville Road
Saint Paul, MN 55127

RE: Project Number(s) SL32991016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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 may be imposed immediately with no opportunity to correct the violation first as follows:

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33991016-0 On June 2, 2025, through June 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 102 residents; 67 residents received services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, June 2, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of two employees (unlicensed personnel (ULP)-B, ULP-C, ULP-E) while providing personal cares. 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).	0 510		

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0 510	Continued From page 4 The findings include: On June 3, 2025, at 12:18 p.m., ULP-B brought R4 from the dining room into R4's apartment. ULP-B and ULP-E donned (applied) gloves. Both ULPs transferred R4 from the Broda chair (oversized wheelchair with cushions) to the hospital bed using a mechanical full body lift. ULP-E held R4 to her left side by log rolling to allow ULP-B to remove the wet pants and saturated brief. ULP-B noted the sling that was under R4 between the Broda chair and pants was also wet, so she placed the sling into R4's bathroom, doffed (removed) gloves and donned clean gloves before applying a new brief and pant. Once R4 was situated in bed to rest, ULP-B grabbed the soiled sling (still wearing gloves), opened the apartment door and exited to bring the sling to the laundry room. ULP-E with same gloves on, grabbed the trash, opened the apartment door and exited. The surveyor followed ULPE-E out of the apartment and noted ULP-E washed her hands after discarding the trash in the trash room off the dining room area. On June 3, 2025, at 12:48 p.m., ULP-E stated she began employment approximately three months ago and did not have prior assisted living service experience. At 12:51 p.m., within R7's apartment, ULP-C and ULP-E donned gloves prior to transferring R7 from the Broda chair to the hospital bed using a mechanical full body lift. R7 was incontinent of bowel and bladder so ULP-C and ULP-E assisted with removing R7's soiled brief. ULP-C had provided perineal care by wiping away the bowel movement of R7's buttocks using her right hand. ULP-C then applied a clean glove over the dirty glove of the right hand and applied a moisture barrier cream to the buttock to help prevent skin break down.	0 510		

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0 510	Continued From page 5 ULP-C then took the second glove used for the cream off and threw it away, leaving the soiled right glove on her right hand and began applying the clean brief to R7. ULP-C and ULP-E both wearing soiled gloves reapplied pants, touched R7's blanket by covering her, touched the bed frame, and ULP-C touched the bed remote to adjust the head and foot of the bed and adjusted R7's pillow. ULP-E moved the mechanical lift, brought the Broda chair into the bathroom. ULP-C removed her gloves, placed them in R7's trash then grabbed the iPad, opened the apartment door and walked out. ULP-C walked to the medication cart and hand sanitized. ULP-E walked out of the apartment still wearing gloves carrying the trash. The surveyor did not observe hand hygiene (hand washing or hand sanitizing) after glove removal and noted multiple surfaces touched with contaminated hands. ULP-B's online training transcript printed June 3, 2025, indicated ULP-B completed infection control training on April 5, 2025. ULP-C's New Hire RA (resident assistant) Skills Competency signed by a registered nurse on June 17, 2024, indicated ULP-C demonstrated skill competency on hand washing and personal protective equipment (gloves). ULP-E's online training transcript printed May 23, 2025, indicated ULP-E completed infection control training on February 15, and 17, 2025. On June 5, 2025, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated staff should be removing dirty gloves after the task, hand sanitized, and put new gloves on and should not	0 510		

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0 510	Continued From page 6 be touching clothes or surfaces with dirty gloves. The licensee's Glove Technique (Non-Sterile) Policy dated 2020, indicated staff to apply non-sterile gloves when touching blood, body fluids, secretions, excretions, contaminated items, mucous membranes, and non-intact skin. Don clean gloves between tasks and procedures on the same resident and remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. Perform hand hygiene after the removal of gloves. The policy also indicated to only wear one glove at a time. The Centers for Disease Control's (CDC) Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings dated April 12, 2024, directed health care workers to wash their hands immediately before touching a [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	0 650		

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0 650	Continued From page 7 chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of three employees (unlicensed personnel (ULP)-C, ULP-N). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 3, 2025, at 9:30 a.m., the surveyor observed multiple residents waiting in the activity area of the secured memory care unit. Four of	0 650		

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0 650	Continued From page 8 those residents were sitting in Broda chairs (oversized wheelchair with cushions). On June 3, 2025, at 11:27 a.m., during lunchtime in the secured memory care unit, the surveyor observed three residents consuming a pureed meal (foods blended into pudding-like texture). ULP-C ULP-C was hired on June 11, 2024, to provide direct care services to the licensee's residents. On June 3, 2025, at 9:30 a.m., ULP-C was with R3 in her apartment providing a nebulizer treatment and explained R3 used 2 liters of oxygen per minute using an oxygen concentrator (concentrates oxygen from ambient air) while in her room because it required to be plugged in. ULP-C said R3 did not have portable oxygen to use so R3 never used oxygen while out of the apartment. ULP-C's record included the following online training dated June 18, 2024: - "Using Oxygen Safely Self-Paced" ULP-C's record lacked the following: -training and demonstrated competency on Broda Chair use; and -demonstrated competency on oxygen use. On June 5, 2025, at 1:27 p.m., ULP-C stated she was trained on how to use the Broda chair with a resident by an onsite nurse. ULP-N ULP-N was hired on January 29, 2025, to provide direct care services to the licensee's residents. ULP-N's training record included online training	0 650		

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0 650	Continued From page 9 "Culinary Special Diet Training with IDDSI 101: Introduction" completed on January 30, 2025. ULP-N's record lacked the following: -demonstrated competency on modified diets including thickened liquids. On June 5, 2025, at 1:25 p.m., ULP-N said she received training by a nurse on modified diets at their corporate training. UPN-N stated the licensee had one resident on thickened liquids (thickening agent added to make liquid more viscose to prevent aspiration) and sometimes the kitchen staff forgot to thicken the liquid so she would go into the kitchen to thicken the resident's beverage herself. On June 3, 2025, at 2:33 p.m., via electronic mail (email), the surveyor requested training for ULP-C to include all delegated training and competencies. Licensed Assisted Living Director (LALD)-D replied to the email at 2:44 p.m., indicating it was requested from human resources. On June 5, 2025, at 10:37 a.m., the surveyor requested documentation of competency on Broda chair and modified diets. Clinical nurse supervisor (CNS)-A stated they had not established a process to determine who was training on what to ensure all trainings were completed. On June 5, 2025, at 12:25 p.m., LALD-D stated regarding modified diet training, their culinary staff are trained on how to prepare modified foods. LALD-D stated ULPs did not thicken liquids and if a snack were needed, ULPs could provide applesauce or pudding. LALD-D stated facility nurses were responsible for training and	0 650		

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0 650	Continued From page 10 ensuring staff were competent on Broda chair use. At 1:20 p.m., LALD-D said they had a Broda chair competency form available to use by the facility nurses. On June 5, 2025, at 1:25 p.m., the surveyor observed ULP-N working in the secured memory care unit. ULP-C stated she was trained on Broda chairs by shadowing other ULPs. ULP-C could not recall if a nurse had trained or performed a return demonstration to the nurse. ULP-C also stated she received training on modified diets at the corporate training class and said the nurse trained her. She stated there was one resident in the memory care unit that required thickened liquids and sometimes the dietary staff would forget to provide it so she would go into the kitchen to use the thickening agent. On June 5, 2025, at approximately 3:00 p.m., during exit conference, regional director of clinical services (RDCS)-H said they were trying to streamline their training documents and said they would need to add Broda chairs to their onsite checklist to be done by facility nurses as they were not done at corporate training. The licensee's Delegation and Supervision Policy updated August 9, 2022, indicated ULPs could perform nursing care services beyond their usual and customary roles when delegated by the RN and perform them under the supervision of an RN. The RN shall provide initial direction by teaching the task utilizing the delegated task form and delegated task orientation form. The RN would verify the ULP was trained and competent and is instructed in the proper methods to perform the task with respect to the specific resident. The policy also indicated the RN would document the training and/or competencies.	0 650		

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HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

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0 650	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had 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). The findings include: On June 3, 2025, the surveyor toured the facility with environmental services director (ESD)-F. The following was observed. There were multiple fire doors leading from the resident rooms to the common hallway in the	0 775		

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0 775	Continued From page 12 dementia care unit that were propped in the open position with wedge style hold open devices between the bottom of the door and the floor. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060		

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01060	Continued From page 13 may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content to the resident or the resident's designated representative after an emergency relocation for one of one resident (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, 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: R5's Service Plan-Attachment E to Residency Agreement signed April 22, 2025, indicated R5 received assistance with medication	01060		

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01060	Continued From page 14 administration, showers, laundry, and homemaking. R5's record included a hospital transfer orders dated April 15, 2025, that indicated R5 was admitted to the hospital on April 14, 2025, and was discharged back to the assisted living on April 15, 2025, with a new stroke diagnosis requiring medication changes. R5's record lacked evidence a written notification was provided to R5 and their designated representative, with the following required content: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities; -if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and -a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On June 5, 2025, at 9:24 a.m., clinical nurse supervisor (CNS)-A stated when a resident was sent to the hospital, they would provide their emergency profile which included a medication list. CNS-A stated she thought the Office of Ombudsman for Long-Term Care (OOLTC) needed to be notified within three days and was	01060		

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01060	Continued From page 15 still learning the licensee's electronic health record (Residex) and would continue searching for evidence the notification was provided to R5. On June 5, 2025, at 11:45 a.m., CNS-A stated they did not have an emergency relocation notification form available to use, but they had the fax sheet to send to OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01420 SS=D	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating treatments and therapies, the	01420		

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01420	Continued From page 16 unlicensed personnel (ULP) were trained by the registered nurse (RN) in the proper methods to perform the care, treatment or therapy for each resident and were able to demonstrate the ability to competently follow the procedure to perform the treatment or therapy for one of two employees (ULP-N). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 3, 2025, at 9:30 a.m., the surveyor observed multiple residents waiting in the activity area of the secured memory care unit. Four of those residents were sitting in Broda chairs (oversized wheelchair with cushions). On June 5, 2025, at 10:04 a.m., clinical nurse supervisor (CNS)-A stated for skills and medication training, they were completed at corporate training (new hire training done outside of the facility). At 10:37 a.m., CNS-A stated the licensee had not established a process on determining what trainings the facility nurses were responsible for completing to ensure all trainings were completed. On June 5, 2025, at 12:25p.m., licensed assisted living director (LALD)-D said the facility nurses were responsible for ensuring the staff were competent on Broda chairs.	01420		

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01420	Continued From page 17 On June 5, 2025, at 1:25 p.m., ULP-N was working in the secured memory care unit and stated she began employment January of this year. She said she was "trained on how to use the Broda chair by shadowing other resident assistants [unlicensed personnel]," and could not recall whether a nurse had trained or observed her demonstrate competency on Broda chair use. ULP-N was hired on January 29, 2025, to provide direct care services to the licensee's residents. ULP-N's employee record lacked training and competency evaluation on use of Broda chairs (oversized cushioned wheelchair). The licensee's Delegation and Supervision Policy updated August 9, 2022, indicated ULPs could perform nursing care services beyond their usual and customary roles when delegated by the RN and perform them under the supervision of an RN. The RN shall provide initial direction by teaching the task utilizing the delegated task form and delegated task orientation form. The RN would verify the ULP was trained and competent and is instructed in the proper methods to perform the task with respect to the specific resident. The policy also indicated the RN would document the training and/or competencies. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 18 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

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01620	Continued From page 19 the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) 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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a change in condition assessment for two of two residents (R4, R5). The licensee also failed to ensure an RN completed a physical device assessment for one of one resident (R6) who utilized a toilet safety rail. 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: During the entrance conference on June 2, 2025, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition (post-hospitalization).	01620		

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01620	Continued From page 20 R4 R4's diagnoses included dementia, intervertebral disc degeneration (lumbar region), chronic kidney disease (stage 3), and cognitive impairment. R4's last nursing assessment was completed on April 3, 2025, indicating R4 required hands-on assist of one person utilizing a gait belt (belt around waist) and walker, assist of one for bed mobility and ambulation with occasional assist of two people, and extensive assistance with toileting by getting R4 on and off the toilet. The assessment also indicated R4 had skin break down on her bottom and to use "Calazime topical or butt paste" for preventative care and for any open areas. The assessment also indicated to use either topical skin protectant for each brief change and hospice (end of life care) would specify orders if wounds were to be covered or not. At the time of this assessment, there were no wounds present. R4's unsigned Service Plan-Attachment E to Residency Agreement printed on June 4, 2025, indicated R4 required assist of two people using a total mechanical lift for transfers, up for meals, incontinence care before transfer out of bed and after transfer back to bed. R4's resident note dated May 6, 2025, written by an RN included instructions provided by hospice regarding wound care to wound on coccyx. R4's resident note dated May 20, 2025, written by an RN, indicated per hospice nurse, pressure sore was healing. R4's resident note dated May 28, 2025, written by an RN, indicated a hospice wound order for hospice to perform a dressing change once a	01620		

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01620	Continued From page 21 week, and if bandage was soiled or dislodged, the facility nurse could change it. The note did not specify where the wound was. During observation on June 3, 2025, at 12:18 p.m., unlicensed personnel (ULP)-B and ULP-E brought R4 from the dining area to R4's room by pushing R4 in the Broda chair (oversized wheelchair with cushions). While both ULPs were getting R4's sling hooked up to a full body mechanical lift (Hoyer), the surveyor observed an absorbent bandage (Mepilex) on R4's left forearm. ULP-B and ULP-E transferred R4 from her Broda chair to the hospital bed with the Hoyer and sling. ULP-E rolled R4 to her left side so ULP-B could remove the soiled brief and perform peritoneal care. The surveyor observed a sizable portion of R4's coccyx and buttock area bright red with a pressure sore (partial thickness loss of skin) approximately 0.5 centimeters in diameter. The surveyor did not observe any bandage to that area. ULP-B placed a clean brief on without applying any type of barrier cream. Both ULPs assisted R4 by putting on clean pants and covering her with a blanket for her to rest in bed. R4 was left lying in bed on her back. The surveyor asked both ULPs if they repositioned R4 while she was in the Broda chair, ULP-B said she did not know how to reposition a resident while in the Broda chair. R4's record lacked a change in condition assessment based on R4's decline in mobility (change in transfer device), change in toileting needs (toilet use to fully incontinent), and also lacked interventions to reduce or eliminate the risk of pressure sores. On June 5, 2025, at approximately 3:00 p.m., licensed assisted living director (LALD)-D stated	01620		

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01620	Continued From page 22 the licensee did not implement a reposition schedule to trigger staff to reposition R4 but would start it due to R4's history of pressure sores. R5 R5's diagnoses included neuropathy of lower extremity (nerve pain), dementia, chronic pain, and arthritis (joint pain) of the knee. R5's Service Plan-Attachment E to Residency Agreement signed April 21, 2025, indicated R5 received assistance with medication administration and management, homemaking, showers, and laundry. R5's record included a hospital transfer orders dated April 15, 2025, that indicated R5 was admitted to the hospital on April 14, 2025, and was discharged back to the assisted living on April 15, 2025, with a new stroke diagnosis requiring medication changes and new medication to reduce chances of stroke again. R5's record lacked a change in condition assessment. R6 R6's diagnoses included Alzheimer's disease, atrial flutter (type of abnormal heart rhythm), syncope and collapse, muscle weakness, and falls. R6's unsigned Service Plan-Attachment E to Residency Agreement printed June 4, 2025, indicated R6 received assistance with medication administration and management, dressing/grooming, toileting, transfers, meals, and escorts.	01620		

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01620	Continued From page 23 On June 3, 2025, at 9:10 a.m., R6 had finished breakfast in the dining room area so ULP-C wheeled her back to her room. Before standing R6 from the manual wheelchair, ULP-C applied a gait belt (belt around waist) and assisted R6 to stand by holding the gait belt. R6 took small, short steps then turned and sat down on her couch. The surveyor observed a walker within R6's room and a toilet safety rail (detached portable railing to assist with sitting or standing while using the toilet). ULP-C stated R6 no longer used the walker and R6 said the toilet railing was helpful. R6's most recent RN assessment dated April 23, 2025, indicated R6 required "extensive assist from staff x2 person assist" but lacked an assessment on whether R6 was safely able to use adaptive equipment while toileting. On June 5, 2025, at 10:14 a.m., CNS-A stated a deviation from the resident normal was considered a change in condition. An example was a change in service(s) and admission to hospice care. CNS-A stated she instructed one of the floor nurses to complete a change in condition assessment for R4 but was unaware it was not completed and should have followed up on that. At 11:15 a.m., CNS-A explained when completing an assessment, she would complete a face to face with the resident to observe what equipment was used and would note that in the appropriate section of the assessment. The licensee's Nursing Assessment Policy updated May 2022, indicated the RN would complete a comprehensive assessment outlined by Minnesota rules to include mobility, ambulation, transfers and assistive devices. The policy also indicated the RN would reassess the	01620		

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01620	Continued From page 24 resident if the resident had a change in condition such as: -decline in functional ability requiring a change in service agreement -change in mobility-related to weakness, stroke, or disease progression -pressure ulcer/injury development -hospitalization No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to	01700		

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01700	Continued From page 25 manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to assess residents for ability to self-administer over the counter (OTC) medications for one of four 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, 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: During the entrance conference on June 2, 2025, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents of the facility. R5's diagnoses included neuropathy of lower extremity (nerve pain), dementia, chronic pain, and arthritis (joint pain) of the knee. R5's Service Plan-Attachment E to Residency Agreement signed April 21, 2025, indicated R5 received assistance with medication administration twice daily.	01700		

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01700	Continued From page 26 During observation and interview on June 3, 2025, at 10:42 a.m., registered nurse (RN)-Q was exiting R5's apartment when surveyor knocked at the door. RN-Q introduced herself and stated she had just completed reviewing R5's medications and exited the apartment. With permission, the surveyor entered and sat in a chair next to R5 (sitting in a recliner). There was a table in between the chairs and a basket on the floor near R5's recliner that contained the following OTC medications: two bottles of acetaminophen (pain reliever), Voltaren gel (topical anti-inflammatory pain relief), Salonpas patches (pain reliever), and Biofeeze gel (topical pain reliever). R5 stated she had the licensee help manage her scheduled medications, so she didn't have to worry about taking them on time. She also stated she used her topical medications for her knees and took acetaminophen occasionally. R5's provider orders signed September 4, 2024, indicated the following: -acetaminophen 500 milligrams (mg), two tablets by mouth as needed, do not exceed 4000 mg in 24 hours; and -Voltaren gel, self-administer and store at bedside. Apply thin layer cream [sic] as needed for back pain. R5's Assessment (nursing assessment) completed on March 3, 2025, indicated the licensee staff administered meds twice per day, including PRNs; staff managed/stored and ordered meds which were kept in the locked medication cart, and that R5 had chronic low back pain where Biofreeze helped the pain temporarily. R5's medical record lacked an assessment indicating R5 could self-administer, manage, and	01700		

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01700	Continued From page 27 store OTC medications. During interview on June 5, 2025, at 10:04 a.m., CNS-A stated the licensee tried to avoid allowing residents to self-administer medications when they provided medication management as it contradicted itself. She stated she would have the provider write an order indicating the resident could self-administer certain medications. CNS-A stated either residents and/or their families would bring in medications and not let staff know so she would be retraining staff (ULPs/RNs to check for OTC medications out in the open) and residents themselves. CNS-A stated RNs completed a medication reconciliation weekly, checked for open dates on medications, checked for expired medications, and ordered supplies. The licensee's Medication Management Policy updated September 19, 2024, indicated the RN would conduct a face-to-face assessment to determine if resident was safe to self-administer medications. Resident reassessment would be conducted during the clinical update and/or with a change in condition if needed to ensure resident remained safe to continue self-administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as	01710		

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01710	Continued From page 28 needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment when admitted to hospice care (end of life) for one of one resident (R6). 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: During the entrance conference on June 2, 2024, at 10:00 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents of the facility. R6 was admitted to licensee for assisted living services on September 5, 2023, and admitted to hospice care on April 25, 2025, with diagnoses of Alzheimer's disease, moderate protein-calorie malnutrition, chronic respiratory failure with hypoxia (low oxygen), and chronic diastolic (congestive) heart failure.	01710		

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01710	Continued From page 29 R6's unsigned Service Plan-Attachment E to Residency Agreement printed on June 4, 2025, indicated R6 received assistance with medication administration four times per day. R4's medication administration record dated December 2024, included two insulins (for diabetes), one beta blocker (for hypertension), one antidepressant, one antihyperlipidemic (for high cholesterol), one proton pump inhibitor (for GERD), and one potassium supplement. During observation on June 3, 2025, at 9:10 a.m., unlicensed personnel (ULP)-C assisted R6 with a pivot transfer from wheelchair to couch using a gait belt (belt around waist). R6's change in condition assessment completed by former registered nurse (RN)-P dated April 23, 2025, assessed R6 had decreased appetite including weight loss, increased generalized weakness, and indicated hospice to evaluate R6 due to resident change in condition. R6's Individualized Medication Management Plan (IMMP) completed by RN-P on April 23, 2025, indicated: "Current list of medications reviewed including the reason taken, dosage, frequency of use, and route administered or taken: Medication list reviewed. Source document was medication list in RTasks [electronic health record] as of 5/24/24." R6's hospice orders dated April 25, 2025, ordered the following medications: -morphine 5 milligram (mg) Solu tab (dissolvable), one tablet by mouth (PO) every 1 hour as needed (PRN) for pain or shortness of breath;	01710		

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01710	Continued From page 30 -lorazepam 0.5 mg tablet, one tablet PO every 4 hours PRN for restlessness, agitation, anxiety and/or shortness of breath; and -Haldol 0.5 mg tablet, one tablet PO every 4 hours PRN for restlessness, agitation, anxiety and/or nausea. R6's medical record lacked a change in condition medication assessment once admitted to hospice with new orders. On June 5, 2025, at 10:04 a.m., CNS-A stated a change in condition was a deviation from the resident's normal such as a change in services and being admitted to hospice. RN-P was unavailable for interview. The licensee's Nursing Assessment Policy updated May 3, 2022, indicated the RN would complete a comprehensive assessment for a change in condition that would include a medication review including over the counter medications, prescription medications and supplements including: 1. Reasons taken 2. Side effects, contraindications, allergic or adverse reactions 3. Actions to address side effects, contraindications, allergic or adverse reactions 4. Dosage 5. Frequency of use 6. Route administered 7. Resident difficulties taking medication 8. Self-administration vs. other type of administration 9. Resident preferences for taking medications 10. Medication management interventions to prevent drug diversion by the resident or others who have access to medications	01710		

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01710	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of one resident (R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01760		

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01760	Continued From page 32 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included vascular dementia, chronic obstructive pulmonary disease (COPD), type 2 diabetes, and obstructive sleep apnea. R3's Master Care Plan dated April 25, 2025, indicated R3 received assistance with medication administration and management. R3's prescriber order signed January 17, 2025, included: -Apply 4 grams Diclofenac Gel 1% topically to lower back and 4 grams each to both knees three times daily for pain. R3's Med Admin Summary-June 2025, included: -Diclofenac Gel 1%, apply 4 grams topically to lower back and 4 grams to each knee three times a day. (8:30 a.m., 2:15 p.m., 8:30 p.m.) During observation on June 3, at 9:30 a.m., the surveyor observed R3 sitting at the edge of her bed receiving a nebulizer while unlicensed personnel (ULP)-C was in the kitchenette area beginning to prepare morning medications. ULP-C set up R3's oral medications by placing them in a medication cup then pulled out of the medication cabinet a box containing Diclofenac gel 1% and used the plastic measure guide (one full strip equaled 4 grams and one-half strip equaled 2 grams) and measured a total of 4 grams and put it into a paper medication cup. ULP-C stated it was 4 grams total for all areas (lower back, and both knees). ULP-C then administered the oral medications and applied Diclofenac gel to R3's lower back and both	01760		

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01760	Continued From page 33 knees. On June 3, 2025, at 11:30 a.m., the surveyor went to the memory care unit's nursing office and asked registered nurse (RN)-G about R3's Diclofenac on the electronic medication administration record (eMAR). RN-G stated the instructions indicated to apply 4 grams to each site and stated it could have been confusing for the ULP, so she updated the instructions to indicate a total of 12 grams to be administered each time. During interview on June 5, 2025, at 10:04 a.m., clinical nurse supervisor (CNS)-A stated she was made aware of the medication error and stated the instructions on the eMAR was a little confusing, but it was correct per the prescriber order. During interview on June 5, 2025, at 1:25 p.m., ULP-N was working in the memory care unit and stated she had administered medications to R3 before. When asked if ULP-N knew how to measure out Diclofenac gel, she stated she was not trained on that and just squeezed a little amount and applied it. The licensee's Medication Management Policy updated September 19, 2024, indicated the registered nurse may delegate medication administration to the ULP only after the RN had verified the ULP was educated and trained in the proper methods to administer the medications and the ULP had demonstrated the ability to competently follow the procedures. The licensee's Medication Error Policy updated November 22, 2023, indicated a medication error occurs when a medication is administered at the	01760		

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01760	Continued From page 34 wrong dose and an RN would complete a follow up and complete a medication error form. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must	01940		

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01940	Continued From page 35 be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include documentation of specific resident instructions relating to the treatments or therapy administration and failed to include procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services for one of one resident (R3) receiving oxygen therapy. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on June 19, 2022, with diagnoses of vascular dementia, chronic obstructive pulmonary disease (COPD), type 2 diabetes, and obstructive sleep apnea. R3's Master Care Plan dated April 25, 2025, indicated R3 received assistance with oxygen management. R3's provider orders dated April 23, 2024, indicated two liters per minute (LPM) of continuous oxygen via nasal cannula (tubing that brings oxygen to the nostrils). R3's record lacked	01940		

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01940	Continued From page 36 current oxygen orders. R3's progress note written by registered nurse (RN)-O on May 22, 2025, at 11:50 a.m. indicated the following on the summary of today's visit: "-Recommend portable O2 [oxygen] when out of the room, does she need supplies?" The surveyor did not observe any additional notes regarding portable oxygen in the record. During observation on June 3, 2025, at 9:30 a.m., R3 was sitting at the edge of her bed receiving a nebulizer treatment while unlicensed personnel (ULP)-C was in the kitchenette area beginning to set up medications. The surveyor observed an oxygen concentrator (concentrates ambient air) next to R3's bed turned off. ULP-C stated R3 did not require oxygen while outside of her room and stated there were no portable oxygen available. ULP-C also stated R3 was independent with mobility, dressing, and using her oxygen. The surveyor asked R3 to demonstrate oxygen application by turning on the concentrator and applied her nasal cannula appropriately. The setting was at 2 LPM. During interview and observation on June 4, 2025, at 12:15 p.m., R3 walked out of her bathroom using her 4 wheeled walker. The surveyor observed her nasal cannula placed on her bed and not worn. R3 stated she never felt dizzy or short of breath without her oxygen. She also stated she never wore oxygen while out of her room including mealtimes in the dining area. During interview on June 5, 2025, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated R3 was required to wear her oxygen at all times and acknowledged they lacked portable oxygen to allow R3 to continue using oxygen while out of	01940		

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01940	Continued From page 37 the room. CNS-A also stated R3's medical record lacked procedures for notifying a registered nurse when a problem arises with treatment or therapy services. The licensee's Treatment and Therapy Management Policy updated March 7, 2023, indicated the registered nurse may delegate to unlicensed personnel the task of providing assistance with treatment and therapy if the unlicensed personnel have satisfied training requirements and if the RN has developed written, specific instructions for each resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronic treatment orders were maintained for one of one resident (R3) who utilized oxygen therapy.	01970		

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HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

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01970	Continued From page 38 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on June 19, 2022, with diagnoses of vascular dementia, chronic obstructive pulmonary disease (COPD), type 2 diabetes, and obstructive sleep apnea. R3's Master Care Plan dated April 25, 2025, indicated R3 received assistance with oxygen management. R3's provider orders dated April 23, 2024, indicated two liters per minute (LPM) of continuous oxygen via nasal cannula (tubing that brings oxygen to the nostrils). R3's record lacked current oxygen orders. During observation on June 3, 2025, at 9:30 a.m., R3 was sitting at the edge of her bed receiving a nebulizer treatment while unlicensed personnel (ULP)-C was in the kitchenette area beginning to set up medications. The surveyor observed an oxygen concentrator (concentrates ambient air) next to R3's bed turned off. ULP-C stated R3 did not require oxygen while outside of her room. ULP-C also stated R3 was independent with mobility, dressing, and using her oxygen. The surveyor asked R3 to demonstrate oxygen application which R3 turned on the concentrator	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32991	A. BUILDING: _____ B. WING _____	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CROSSING	4650 CENTERVILLE ROAD SAINT PAUL, MN 55127

(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
01970	Continued From page 39 and the setting was at 2 LPM and applied her nasal cannula appropriately. During interview and observation on June 4, 2025, at 12:15 p.m., R3 walked out of her bathroom using her 4 wheeled walker. The surveyor observed her nasal cannula placed on her bed and not worn. R3 stated she never felt dizzy or short of breath without her oxygen. She also stated she never wore oxygen while out of her room. During interview on June 5, 2025, at 11:45 a.m., clinical nurse supervisor (CNS)-A stated treatment and therapy orders are renewed annually. CNS-A stated R3's oxygen order was available on R3's "MD Orders" dated June 12, 2024, but surveyor could not locate the providers instructions including quantity, directions for use, and length of use. CNS-A acknowledged the missing information and stated she would enter the oxygen service into the medication administration record going forward so it would include all of the missing information when the provider signs the form. The licensee's Treatment and Therapy Management Policy updated March 7, 2023, indicated the licensee would obtain treatment or therapy orders by provider and monitor its progress and update the provider as needed. The policy did not indicate the licensee would obtain orders annually. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Harbor Crossing
4650 Centerville Road
White Bear Lake, MN 55127
Ramsey County
Parcel:

Phone:
kfletcher@preshomes.org

License Info

License: HFID 32991

Risk:
License:
Expires on:
CFPM: Katherine Fletcher
CFPM #: 55407; Exp: 1/21/2028

Inspection Info

Report Number: F1031251035
Inspection Type: Follow-up - Single
Date: 6/16/2025 Time: 10am
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: In Person

Previous Order: 4-400 Equipment Location and Installation
4-402.11A *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.
COMMENT:
6/17/2025 REPEAT VIOLATION:
HANDWASH SINK IN SERVICE AREA NEEDS TO HAVE RIGHT SIDE BY WALL CLEANED AND SIDE OF SINK SILICONED TO COUNTER.
Comply By: 6/23/2025 Originally Issued On: 6/2/2025

Previous Order: 4-600 Cleaning Equipment and Utensils
4-602.13 *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.
COMMENT:
6/17/2025 REPEAT VIOLATION:
1. COOK LINE EQUIPMENT HAS GREASE/SPLASHES/SPILLS ON EQUIPMENT SURFACES.
CLEAN ALL COOK LINE EQUIPMENT SURFACES AND KNOBS.
NO GREASE SHOULD REMAIN AFTER CLEANING.
2. KITCHEN HAS MULTIPLE PIECES OF EQUIPMENT WITH FOOD DEBRIS ON OR BEHIND HANDLES.
CLEAN ALL HANDLES IN KITCHEN.
Comply By: 6/23/2025 Originally Issued On: 6/2/2025

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1031251035 from 6/16/2025

Rob McNeill
Nutrition & Culinary Director

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728

chris.j.foster@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Harbor Crossing
White Bear Lake
County/Group: Ramsey County

Inspection Info

Report Number: F1031251035
Inspection Type: Follow-up
Date: 6/16/2025
Time: 10am

Food Temperature: Product/Item/Unit: Fruit**; Temperature Process:** Cold-Holding
Location: 1-Door Cooler at 38.6 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Salsa **; Temperature Process:** Cold-Holding
Location: 1-Door Cooler at 38.8 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Harbor Crossing
4650 Centerville Road
White Bear Lake, MN 55127
Ramsey County
Parcel:

Phone:

License Info

License: HFID 32991

Risk:
License:
Expires on:
CFPM: Katherine Fletcher
CFPM #: 55407; Exp: 1/21/2028

Inspection Info

Report Number: F1031251029
Inspection Type: Full - Single
Date: 6/2/2025 Time: 11am
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 5
Delivery: In Person

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT:
MULTIPLE ITEMS IN 1-DOOR COOLER ON COOK LINE MEASURED ABOVE 41F.
ALL TCS FOODS DISCARDED.
DISCONTINUE USE OF 1-DOOR COOLER UNTIL REPAIRED.
Comply By: 6/2/2025 Originally Issued On: 6/2/2025

New Order: 4-400 Equipment Location and Installation
4-402.11A *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.
COMMENT:
THE FOLLOWING AREAS HAVE DAMAGED OR MISSING SILICONE:
1. 2-COMP PREP SINK
2. HANDWASH AND DUMP SINKS IN SERVICE AREA.
REMOVE ANY OLD SILICONE, CLEAN AREA, AND RESILICONE WITH 100% SILICONE.
Comply By: 6/23/2025 Originally Issued On: 6/2/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT:
1-DOOR COOLER ON COOK LINE IS NOT KEEPING FOODS 41F OR BELOW.
HAVE COOLER REPAIRED.
CONTACT INSPECTOR ONCE REPAIRED.
Comply By: 6/2/2025 Originally Issued On: 6/2/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT: **1. CAN OPENER FOUND WITH FOOD BUILDUP ON BLADE.**
2. EMERSION BLENDERS FOUND WITH FOOD DEBRIS ON BLADES, HANDLES, CORDS, AND BODIES.
ALL ITEMS SENT TO DISH FOR CLEANING.
CHECK ALL FOOD CONTACT ITEMS FOR DEBRIS PRIOR TO USE AND CLEAN AFTER USE.
Comply By: 6/2/2025 Originally Issued On: 6/2/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11B *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.
COMMENT:
CONVECTION OVEN INTERIOR HAS ENCRUSTED FOOD DEBRIS THROUGHOUT CAVITY AND DOORS.
CLEAN CONVECTION OVEN INTERIOR, DOORS, AND GLASS.
Comply By: 6/23/2025 Originally Issued On: 6/2/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.11E *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.
COMMENT:
OBSERVED A YELLOWISH SUBSTANCE ON ICE MACHINE BAFFLE.
REMOVE AND CLEAN BAFFLE AND ANY OTHER AREAS INSIDE ICE BIN WHERE DISCOLORATION/IMPURITIES ARE PRESENT.
Comply By: 6/23/2025 Originally Issued On: 6/2/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.13 *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.
COMMENT:
1. COOK LINE EQUIPMENT HAS GREASE/SPLASHES/SPILLS ON EQUIPMENT SURFACES.
CLEAN ALL COOK LINE EQUIPMENT SURFACES AND KNOBS.
NO GREASE SHOULD REMAIN AFTER CLEANING.
2. KITCHEN HAS MULTIPLE PIECES OF EQUIPMENT WITH FOOD DEBRIS ON OR BEHIND HANDLES.
CLEAN ALL HANDLES IN KITCHEN.
Comply By: 6/23/2025 Originally Issued On: 6/2/2025

Food & Beverage General Comment

Establishment has a full commercial kitchen.

All violations discussed with PIC prior to leaving site.

Discussed:
- Cooling and reheating procedure
- Eggs
- Fully cooking all foods
- Vomit cleanup

- Illness and illness log

NOTES:
1. Soups received from Optage Meals - Commissary Kitchen
2. Pest control service: Plunkets

ILLNESS COMPLAINT PROCEDURE:
If any customer complains of illness take these steps:
1. Gather as much information from the customer as possible, such as: name, phone#, date of illness, food consumed.
2. Give customer the illness hotline phone number: 1-877-366-3455.
3. Contact your health inspector: Give inspector information gathered from customer and any other useful information.

Contact inspector prior to any major equipment or building changes; some changes may require plan review to be completed.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1031251029 from 6/2/2025

Kate Fletcher
Traveling Nutrition & Culinary Director

Chris Foster, REHS/RS
Public Health Sanitarian 3
651-201-4728
chris.j.foster@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Harbor Crossing
White Bear Lake
County/Group: Ramsey County

Inspection Info

Report Number: F1031251029
Inspection Type: Full
Date: 6/2/2025
Time: 11am

Food Temperature: Product/Item/Unit: Chicken Breast**; Temperature Process:** Cold-Holding
Location: 1-Door Cooler at 44 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Eggs HB**; Temperature Process:** Cold-Holding
Location: 1-Door Cooler at 47 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Cut Fruit**; Temperature Process:** Cold-Holding
Location: 1-Door Cooler at 55 Degrees F.
Comment:
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Roast Beef**; Temperature Process:** Hot-Holding
Location: Steam Table at 144 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Salmon**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Soup**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Tomatoes; Sliced**; Temperature Process:** Cold-Holding
Location: Prep Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: 1-Door Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Dressing**; Temperature Process:** Cold-Holding
Location: 1-Door Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: 1-Door Undercounter Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

<u>Food Temperature</u>: Product/Item/Unit: Soup**; Temperature Process:** Hot-Holding
Location: Soup Warmer at 164 Degrees F.
Comment:
Violation Issued?: No

<u>Equipment Temperature</u>: Product/Item/Unit: Ambient**; Temperature Process:** Cold-Holding
Location: Glass Door Tabletop Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
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St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Harbor Crossing
White Bear Lake
County/Group: Ramsey County

Inspection Info

Report Number: F1031251029
Inspection Type: Full
Date: 6/2/2025
Time: 11am

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 169 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Cook Line **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Prep **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 700 Degrees F.
Comment:
Violation Issued?: No