Electronically Delivered

February 7, 2023

Licensee
The Shores Of Lake Phalen
1870 East Shore Drive
Maplewood, MN 55109

RE: Project Number(s) SL29004015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 28, 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:
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Health Regulation Division
Minnesota Department of Health
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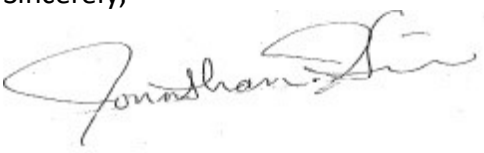
St. Paul, MN 55164-0970

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
	29004	A. BUILDING: _____ B. WING _____	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHORES OF LAKE PHALEN	1870 EAST SHORE DRIVE MAPLEWOOD, MN 55109

(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: SL29004015-0 On December 27, 2022, through December 28, 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-two (72) residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and 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 had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report,	0 480		

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0 480	Continued From page 2 dated December 27, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=E	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 and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff appropriately gloved and performed adequate hand hygiene (HH) for 2 of 3 staff (unlicensed personnel (ULP)-D, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited	0 510		

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0 510	Continued From page 3 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D ULP-D was hired December 6, 2022, and provided direct care services for residents. On December 27, 2022, from 3:08 p.m. to 3:45 p.m., ULP-D was continuously observed during a medication administration. ULP-D entered R7's room and administered medications to R7. No HH was observed. -at 3:12 p.m., ULP-D returned to the medication cart and prepared medications for R8. ULP-D entered R8's room, and washed hands with soap and water, rubbing soaped hands under the water stream for five seconds. ULP-D donned a glove on the right hand only, then used a tissue to hold open R7's eye with the ungloved hand, while instilling medication into the eye from the bottle in the gloved right hand. With partially gloved hands, ULP-D then gathered dirty dishes from R8's room, disposed of food in the garbage and placed dishes into the kitchen area, doffed the soiled right hand glove, returned the eye drop bottle to the medication cart, and documented the administration in the paper medication administration record (MAR). -at 3:22 p.m., ULP-D performed HH with soap and water for eight seconds. ULP-D entered R5's room, donned gloves to both hands and performed incontinence cares including cleansing the perineal area and changing a soiled incontinence brief. Without removing the soiled gloves and performing HH, ULP-D then applied barrier cream to R5's sacrum and buttocks. ULP-D disposed of the soiled wipes and brief.	0 510		

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0 510	Continued From page 4 Without removing the soiled gloves, ULP-D repositioned R5, adjusted R5's clothing, then doffed the soiled gloves. Without performing HH, ULP-D positioned R5's feet onto a pillow, and covered R5 with a blanket. ULP-D then emptied R5's garbage, carried the garbage to the kitchen, returned to the medication cart and documented the task completed in the paper MAR. No HH was observed. -at 3:44 p.m., ULP-D unlocked the medication cart, opened the paper MAR, then went to the kitchen sink and performed HH using soap and water for five seconds. ULP-D returned to the medication cart and stated she would then administer one medication to R9. On December 27, 2022, at 3:45 p.m., ULP-D stated she was trained to perform HH for 30 seconds. ULP-D further stated she did not perform HH for 30 seconds between residents during the observation. ULP-I ULP-I was hired October 6, 2020, and provided direct care services for residents. On December 27, 2022, at 4:03 p.m., ULP-I was observed to check the blood glucose level for R4. ULP-I verified the order in the paper MAR and performed HH with soap and water, rubbing soaped hands under the water stream for six seconds. ULP-I then gathered supplies including the glucometer in a closed plastic box, knocked and entered R4's room, and donned gloves. ULP-I checked R4's blood glucose returned the glucometer to the plastic box, closed the box, doffed gloves, and assisted R4 to stand and walk with a walker to the dining room. ULP-I then unlocked the medication cart, returned the plastic box containing the glucometer to the drawer,	0 510		

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0 510	Continued From page 5	0 510		

closed the drawer and documented in the paper MAR. ULP-I was not observed to perform HH.
-at 4:14 p.m., after being cued by the surveyor, ULP-I was observed to perform HH using soap and water, rubbing soaped hands under the water stream for 15 seconds.

On December 27, 2022, at 3:53 p.m., registered nurse (RN)-B stated new employees received online training and a video regarding HH. RN-B further stated staff was trained to wash hands for 20-30 seconds, singing "happy birthday" twice. RN-B further stated after performing incontinence cares, the caregiver should don clean gloves before applying a topical barrier cream medication.

The CDC guidance titled, Hand Hygiene in Healthcare Settings, dated January 8, 2021, indicated healthcare personnel (HCP) should perform HH before and after all patient contact, contact with potentially infectious material, and immediately before donning and after doffing gloves. The CDC indicated gloves should be changed and HH performed before moving from work on a soiled body site to a clean body site on the same patient. The CDC recommended alcohol-based hand sanitizer (ABHS) with 60% to 95% alcohol, or washing hands with soap and water for at least 15 seconds.

The licensee's Hand Washing infection control policy, dated August 1, 2021, indicated hands should be washed by wetting hands, applying soap, and rubbing vigorously for at least 20 seconds, then rinsing thoroughly under running water. The policy further indicated, "When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing

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0 510	Continued From page 6 gloves." The licensee's Gloves infection control policy, dated August 1, 2021, indicated, "Gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed." The policy further indicated the gloving procedure included washing hands, applying gloves to both hands, and rewashing hands after doffing gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually	0 680		

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0 680	Continued From page 7 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 27, 2022, at 12:24 p.m., the licensee's EP plan was reviewed and noted to lack customization to the facility and resident-specific individualization. The licensee-provided EP policy, undated, lacked a documented annual review date, and individualized emergency procedures to include the following: -a risk assessment considering all hazards that may impact all or a portion of the facility; - an assessment of the at risk population's needs; - a process for emergency preparedness	0 680		

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0 680	Continued From page 8	0 680		

cooperation with state and local EP officials/organizations;
-policies and procedures to address evacuation and shelter in place for staff and residents which must include:
- food, water, medical supplies, pharmaceutical supplies;
- alternate sources of energy to maintain temperature, safety and sanitary storage of provisions, emergency lighting;
- alternate sources of energy to fire detection, extinguishing, alarms systems;
- sewage and waste disposal;
- a tracking system used to document locations of residents and staff;
- the medical record documentation system to preserve resident information;
- handling and use of volunteers;
- how the facility would operate under an 1135 waiver;
- a communication plan that included:
- names and contact information for staff, resident physicians, other facilities; and
- a method of sharing information and medical documentation for residents.

On December 27, 2022, at 1:28 p.m., licensed assisted living director (LALD)-A stated the EP had been reviewed once, but could not say when, or if it had been reviewed prior to her becoming the LALD. LALD-A further stated there was no additional EP information beyond what was reviewed and indicated they had not yet developed a hazard vulnerability assessment. LALD-A stated they would be researching a more comprehensive framework to use for their EP plan.

The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021,

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0 680	Continued From page 9 indicated, "[Licensee] will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 10 by: Based on observation and interview, the licensee failed to provide the interconnection of required smoke alarms in the one-bedroom resident apartment unit #318, combined resident apartment unit #335/333, and combined resident apartment unit #336/338. This has the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 28, 2022, approximately from 11:15 p.m. to 2:40 p.m. survey staff toured the facility with the director of maintenance (DOM)-J. During the tour, survey staff observed and the DOM-J verified the following: 1. The sets of apartment units (#333/335 and #336/338) were remodeled by combining the two studio-type apartment units into one unit through the use of a set of connecting French doors. The smoke alarms were tested by the DOM-J and were not interconnected to sound throughout as required. The finding was evident when the DOM-J tested the smoke alarms and each sound locally. Survey staff explained to the DOM-J that the remodeled combined studios are now considered as one apartment unit and the smoke alarms inside the apartment unit must be interconnected so both smoke alarms would sound when one alarm is activated in the	0 780		

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0 780	Continued From page 11 apartment unit for compliance with statutes, and this applies to all similar remodeled apartment units. 2) In the one-bedroom apartment unit 318, smoke alarms were not interconnected. The finding was evident when the DOM-J tested the smoke alarms by activating each smoke alarm and each sounded local and failed to sound the other smoke alarm. The DOM-J confirmed the finding as he stated that it could be different types/brands of smoke alarms installed when they replaced the smoke alarm. On December 28, 2022, at approximately 3:45 p.m., during the exit interview, the DOM-J and the licensed assisted living director-A acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and	0 800		

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THE SHORES OF LAKE PHALEN	1870 EAST SHORE DRIVE MAPLEWOOD, MN 55109

(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
0 800	Continued From page 12	0 800		

operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected

On December 28, 2022, approximately from 11:15 p.m. to 2:40 p.m. survey staff toured the facility with the director of maintenance (DOM)-J. During the tour, survey staff observed and the DOM-J verified the following:

1. Emergency lights near the east 1st-floor stair exit light and the 3rd-floor stair exit light near apartment 340 were not working.
2. The fire-rated doors for the laundry rooms (2nd and 3rd floor) and the trash rooms (2nd and 3rd floor) were wedged in open positions which compromised the fire safety of the corridors. All fire-rated doors must be in proper working order to maintain the integrity corridor to protect the residents, staff, and visitors during a fire. In addition, The fire-rated laundry door (3rd floor) failed to latch positively when closed.
3. In apartment unit 231, the bedroom carpet flooring was dirty and soiled. The DOM-J confirmed the finding.
4. Extension cords were used in apartment units 125 and 337. The use of extension cords must not be used as the extension cords pose a potential electrical fire hazard from overloading the electrical circuits.
5. No protective barriers were provided to prevent residents from directly contacting the gas fireplaces when in operation. The gas fireplace

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0 800	Continued From page 13 near the front lobby was in operation and was hot when touched by survey staff and the DOM-J during the survey. The DOM-J confirmed the finding. On December 28, 2022, at approximately 3:45 p.m. during the exit interview, the DOM-J and the licensed assisted living director-A acknowledged the above findings. Additional information from the DOM-J via email received on 12/30/2022, at 10:15 a.m. for documentation on fire alarm system inspection and test, dated October 24, 2022. 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 plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 14 (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 record review and interview, the licensee failed to provide the complete content of the fire safety and evacuation plan, the minimum required evacuation drills, and the required employee training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 28, 2022, at approximately 11:10 a.m., survey staff requested the fire safety and evacuation documentation, evacuation drill, and training documentation from the director of	0 810		

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0 810	Continued From page 15 maintenance (DOM)-J and the licensed assisted living director (LALD)-A. At approximately 2:40 p.m., survey staff received and reviewed the documentation. On December 28, at 3:30 p.m., a documentation review and interview were performed with the LALD-A and DOM-J indicated the following: 1. The fire safety and evacuation plan documentation did not include or address the identification of unique or unusual resident needs for movement or evacuation for resident movement, evacuation, or relocation during a fire or similar emergency. Survey staff explained to the LALD-A and the DOM-J that unique resident situations must be considered during an evacuation including residents with mobility limitations, cognitive impairment, deaf or blind, or any residents needing assistance including movement and evacuation that must be addressed in the fire safety and evacuation plan. 2. Record review indicated the licensee failed to provide the required minimum numbers of fire evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill every other month, a total of a minimum of six drills per year. The fire drill documentation provided for review showed one fire drill record dated November 26, 2022, and also lacked evacuation drill information. The LALD-A and the DOM-J confirmed the finding. 3. The licensee did not meet the minimum required employee fire safety and evacuation training twice per year in addition to new employee orientation. The facility's fire procedure training policy (undated) incorrectly stated that at least annually after orientation. Employee training record provided also showed fire safety and evacuation training dated September 27, 2022, to	0 810		

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0 810	Continued From page 16 date for the year 2022. On December 28, 2022, at approximately 3:45 p.m., during the exit interview, the LALD-A and DOM-J acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding	0 950		

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0 950	Continued From page 17 subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative, on a separate form, including statutory language, for five of five residents (R1, R2, R3, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on July 30, 2021, and received services including assistance with safety checks, toileting, shower, walking, dressing, transfers, laundry, and medication management. R2 was admitted on December 3, 2021, and received services including assistance with safety checks, shower, dressing/grooming, transfers, toilet, catheter/urostomy, catheter/colostomy, and medication management. R3 was admitted on October 1, 2021, and received services including assistance with safety checks, shower, dressing/grooming, and medication management.	0 950		

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0 950	Continued From page 18 R4 was admitted October 10, 2022, and received services including assistance with safety checks, toileting, grooming, dressing, laundry, shower, blood glucose monitoring, and medication management. R5 was admitted December 11, 2021, and received services including assistance with repositioning, toileting, transfers, safety checks, toileting, shower, and medication management. R1, R2, R3, R4, and R5's assisted living contract's dated, July 30, 2021, December 3, 2021, October 1, 2021, October 10, 2022, and December 11, 2021, respectively, included a signature line indicating a designated representative, but lacked required statutory language provided on a form separate from the contract. On December 28, 2022, at 9:17 a.m., licensed assisted living director (LALD)-A indicated the right to designate a representative statutory language was not present anywhere in the current assisted living contract. LALD-A further stated all residents were provided the same contract. The licensee's Designated Representative policy, dated August 1, 2021, indicated "Before or at the time of execution of an assisted living contract, [licensee] will offer residents the opportunity to identify a designated representative in writing. A signed Designated Representative form must be filled out documenting the residents' choice in designated representative, the form will be kept in the resident record." The policy further indicated the designated representative form would include the following verbatim language, ""RIGHT TO DESIGNATE A REPRESENTATIVE FOR	0 950		

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0 950	Continued From page 19 CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living at the facility. This practice resulted in a level two violation (a	0 970		

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0 970	Continued From page 20 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted on July 30, 2021, and received services including assistance with safety checks, toileting, shower, walking, dressing, transfers, laundry, and medication management. R2 was admitted on December 3, 2021, and received services including assistance with safety checks, shower, dressing/grooming, transfers, toilet, catheter/urostomy, catheter/colostomy, and medication management. R3 was admitted on October 1, 2021, and received services including assistance with safety checks, shower, dressing/grooming, and medication management. R4 was admitted October 10, 2022, and received services including assistance with safety checks, toileting, grooming, dressing, laundry, shower, blood glucose monitoring, and medication management. R5 was admitted December 11, 2021, and received services including assistance with repositioning, toileting, transfers, safety checks, toileting, shower, and medication management. R1, R2, R3, R4, and R5's record included an assisted living contract, titled Residency Agreement, signed July 30, 2021, December 3,	0 970		

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0 970	Continued From page 21 2021, October 1, 2021, October 10, 2022, and December 11, 2021, respectively, included the following language indicating a waiver of liability: Pg 12-13 section 3.4 Personal Injury and property damage: "The Resident agrees to pay for any damage that the Resident or the Resident's guests cause to the Community or to the Community's property. Ordinary wear and tear are not considered damage. The Resident shall be liable for any injuries to other persons in the Community caused by the Resident or the Resident's guests. If any person seeks to recover from the Community for injuries or damages caused by the Resident or the Resident's guests, then the Resident agrees to reimburse the Community for any sums paid or any costs incurred by the Community, including attorneys' fees. Accordingly, it is recommended that the Resident obtain an appropriate insurance policy on his or her behalf." On December 28, 2022, at 9:17 a.m., licensed assisted living director (LALD)-A stated the language would be changed to align with the statute. LALD-A further stated all residents were provided the same contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all	01370		

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01370	Continued From page 22 unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	01370		

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01370	Continued From page 23 Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required content, for two of two employees (unlicensed personnel (ULP)-D, ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E ULP-E was hired to provide comprehensive home care services on March 10, 2020; ULP-E began providing assisted living services on August 1, 2021. On December 28, 2022, starting at 7:00 a.m., ULP-E administered medications to residents R2 and R3. ULP-E's employee record lacked evidence ULP-E had received the following training and competency: -documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; -maintenance of a clean and safe environment; -training on the prevention of falls; - medication, exercise, and treatment reminders; and - awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 24 On December 28, 2022, at 2:30 p.m., RN-B stated she was unable to find the missing training and RN-B did not work for the facility when ULP-E was hired. The licensee's Competency Training Evaluations policy, dated August 1, 2021, directed training and competency evaluations for all ULPs include the following: -documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility; - basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 25 -awareness of commonly used health technology equipment and assistive devices. ULP-D ULP-D was hired to provide assisted living services on December 6, 2022. On December 27, 2022, starting at 3:08 p.m., ULP-D administered medications to R7, R8 and R9. ULP-D's employee record lacked evidence ULP-D received the following training and competency: -documentation requirements for all services provided; -maintenance of a clean and safe environment; and -stand-by assistance techniques. On December 28, 2022, at 1:55 p.m., registered nurse (RN)-B stated she was in charge of caregiver training. RN-B further stated all training provided for ULP-D would be found in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and	01380		

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01380	Continued From page 26 changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired to provide assisted living services on December 6, 2022. On December 27, 2022, starting at 3:08 p.m., ULP-D administered medications to R7, R8 and R9. ULP-D's employee record lacked evidence	01380		

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01380	Continued From page 27 ULP-D received the following training and competency: -observation, reporting, and documenting of client status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the client. On December 28, 2022, at 1:55 p.m., registered nurse (RN)-B stated she was in charge of caregiver training. RN-B further stated all training provided for ULP-D would be found in the employee record. The licensee's Competency Training Evaluations policy, dated August 1, 2021, indicated, "training and competency evaluation for unlicensed personnel providing assisted living services must include: a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01380		

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01380	Continued From page 28 (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of two employees (unlicensed personnel (ULP)-E) with employee records reviewed.	01440		

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01440	Continued From page 29 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired to provide comprehensive home care services on March 10, 2020; ULP-E began providing assisted living services on August 1, 2021. The employee record of ULP-E did not contain documentation that ULP-E had been supervised after performing delegated tasks. On December 28, 2022, at approximately 2:30 p.m. RN-B verified there was no documentation that ULP-E had been supervised after performing delegated tasks, and stated RN-B was not working at the facility when ULP-E was hired. The licensee's Supervision of Staff-Delegated Services policy, dated August 1, 2021, directed direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the licensee and performs the delegated task. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01470	Continued From page 30	01470		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	01470		

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01470	Continued From page 31 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to include all required content for two of three employees (registered nurse (RN)-B, and unlicensed personnel (ULP)-D). 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: RN-B was hired December 27, 2020, and provided direct cares for residents of the facility.	01470		

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01470	Continued From page 32 RN-B's employee record lacked documentation the following orientation topics were completed: -An overview of the appropriate Assisted Living statutes 144 G and rules; -Review of providers policies and procedures; -Consumer advocacy services; and -Review of types of Assisted Living services the employee will provide and provider's scope of license. ULP-D was hired December 6, 2022, and provided direct cares for residents of the facility. On December 27, 2022, at 3:08 p.m., ULP-D was observed administering medications to residents. ULP-D's employee record lacked documentation the following orientation topics were completed: -An overview of the appropriate Assisted Living statutes 144 G and rules; and -Consumer advocacy services. On December 27, 2022, at 1:23 p.m., RN-B stated they reviewed the new statutes at an all-staff meeting, but the training was not documented for RN-B. On December 28, 2022, at 1:55 p.m., RN-B stated licensed assisted living director (LALD)-A was in charge of the statute and policy orientation. RN-B further stated RN-B and ULP-D lacked documentation of the orientation topics listed above. In addition, RN-B stated ULP-D's orientation would not be documented elsewhere. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated, "All staff of [licensee] providing and supervising direct services must complete an	01470		

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01470	Continued From page 33 orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01480 SS=D	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for one of two employees (unlicensed personnel (ULP)-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01480		

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01480	Continued From page 34 On December 28, 2022, at approximately 8:00 a.m., ULP-E provided catheter care and activities of daily living to resident (R)-1. ULP-E was hired on March 10, 2020. ULP-E's record lacked documentation of orientation to each resident and services to be provided. On December 28, 2022, at approximately 8:00 a.m., ULP-E stated ULP-E was trained to provide services to the residents in the facility by a nurse who no longer worked at the facility. On December 28, 2022, at approximately 2:30 p.m., registered nurse (RN)-B acknowledged no documentation of orientation to each resident in the record of ULP-E. RN-B stated each ULP is required to spend time with the registered nurse and other ULPs to learn about each resident's services and needs prior to providing any services, but RN-B did not work at the facility when ULP-E was hired. The licensee's Orientation of Staff and Supervisors & Content policy, dated August 1, 2021, indicated staff would be orientated specifically to each individual resident and the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01480		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790		

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01790	Continued From page 35	01790		

nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;
(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and
(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.
(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:
(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and
(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:
(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;
(ii) how the container or containers must be labeled;
(iii) written information about the medications to be provided;
(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of

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01790	Continued From page 36	01790		

medications that were provided to the resident, and other required information;
(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;
(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and
(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.

This MN Requirement is not met as evidenced by:
Based on record review and interview, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

ULP-E
ULP-E was hired to provide comprehensive home

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01790	Continued From page 37 care services on March 10, 2020; ULP-E began providing assisted living services on August 1, 2021. ULP-E's employee record lacked evidence the registered nurse (RN) had trained ULP-E and determined ULP-E was competent to follow the procedures for giving medications to residents for unplanned time away from home. On December 28, 2022, at 2:30 p.m., RN-B confirmed ULP-E's record lacked the documentation of training for giving medications to residents for unplanned time away from the facility, and RN-B stated that an RN generally provided this training to new ULPs at the facility, but RN-B was not working at the facility when ULP-E was hired. The licensee's Medication Management-Planned and Unplanned Time Away policy, dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse is not available, the RN may delegate this task to a ULP if the ULP is properly trained and competency tested. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store medications according to the manufacturer's directions for two of two residents (R3, R4) who required insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 was admitted on September 21, 2021, with diagnoses including type 2 diabetes and dementia. R3's Service Plan Agreement, dated October 20, 2022, indicated R3 received medication management services. R3's medication administration record, dated December 1, 2022, through December 31, 2022, indicated R3 received Lantus Solo Star insulin one time per day via a pen injector. On December 28, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-E administered insulin to R3 via a Lantus insulin pen. ULP-E retrieved the Lantus insulin pen from a refrigerator in R3's apartment. There was no thermometer in this refrigerator. On December 28, 2022, at approximately 9:20	01880		

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01880	Continued From page 39 a.m., registered nurse (RN)-B stated she had just become aware that no refrigerator temperature logs were maintained to ensure that insulin pens of residents were stored according to manufacturer's specifications, and she had ordered thermometers for refrigerators of all residents who stored insulin pens in their refrigerators. The Lantus insulin pen manufacturer's instructions, dated August 2022, directed unopened insulin pens be stored in a refrigerator at approximately 36°Fahrenheit (F) to 46°F, and do not allow the insulin to freeze. These manufacturer's instructions directed opened insulin pens be stored at room temperature, less than 86°F. R4's service plan, dated October 10, 2022, indicated R4 received services including assistance with medication management. R4's medication administration record (MAR) for December 2022, indicated R4 was administered Humalog Kwikpen (insulin lispro, a fast-acting insulin), and Toujeo SoloStar (insulin glargine-a long-acting insulin) daily from December 5 through December 28, 2022. On December 27, 2022, at 4:03 p.m., the surveyor observed R4's in-room medication storage. R4's open Humalog Kwikpen and Toujeo SoloStar pen were located inside the refrigerator in a locked box. The locked box further contained 2 unopened boxes plus one unused Humalog Kwikpen. No thermometer was observed in the refrigerator. ULP-I stated all insulin was stored in the resident refrigerator. ULP-I further stated caregivers did not maintain a temperature log for	01880		

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01880	Continued From page 40 R4's refrigerator. On December 27, 2022, at 4:24 p.m., registered nurse (RN)-B stated all insulins are stored in the residents' refrigerator. RN-B further stated refrigerator temperatures were not monitored. RN-B indicated digital thermometers were ordered and would be used to monitor refrigerator temperatures. The manufacturer's instructions for the use of the Humalog Kwikpen pen dated April 2020, directed, "Store unused Pens in the refrigerator at 36° F to 46° F (2° C to 8° C)". The instructions further directed, "Store the Pen you are currently using at room temperature [up to 86° F (30°C)]". The manufacturer's instructions for the use of the insulin Toujeo SoloStar dated August 2022, directed , "Keep new pens in the refrigerator between 36°F and 46°F (2°C and 8°C)". The instructions further indicated after first use, "Keep your pen at room temperature up to 86°F (30°C)" and "Do not put your pen back in the refrigerator". The licensee's Medication storage policy dated August 1, 2021, indicated medications would be stored per manufacturer's directions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890		

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01890	Continued From page 41 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained, including the opened date for time sensitive medication storage for one of two residents (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: R4's service plan, dated October 10, 2022, indicated R4 received services including assistance with medication management. R4's medication administration record (MAR) for December 2022, indicated R4 was administered Humalog Kwikpen (insulin lispro, a fast-acting insulin), and Toujeo SoloStar (insulin glargine-a long-acting insulin) daily from December 5 through December 28, 2022. On December 27, 2022, at 4:03 p.m., the surveyor observed R4's in-room medication storage. R4's Humalog Kwikpen and Toujeo SoloStar pen opened without labels to indicate the date staff first used the insulins and when the	01890		

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01890	Continued From page 42 insulins would expire. ULP-I stated insulin was kept in R4's refrigerator in locked box. ULP-I confirmed insulin pens were opened and lacked identification of the date opened. ULP-I stated the staff who opened the insulin, should have dated it. On December 27, 2022, at 4:24 p.m., registered nurse (RN)-B stated insulin pens should be dated when opened and first used. The manufacturer's instructions for the use of the Humalog Kwikpen pen dated April 2020, directed for the insulin to be discarded 28 days after being opened. The manufacturer's instructions for the use of the insulin Toujeo SoloStar dated August 2022, directed for the insulin to be discarded 56 days after being opened. The licensee's Medication storage policy dated August 1, 2021, indicated medications would be stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01940		

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01940	Continued From page 43 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 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 develop and implement a treatment or therapy management plan to include all required content for one of four residents (R4) receiving treatment 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) 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	01940		

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01940	Continued From page 44 only occasionally). The findings include: R4 had diagnoses including diabetes mellitus, dementia, and chronic kidney disease. On December 27, 2022, at 4:03 p.m. unlicensed personnel (ULP)-I was observed to assist R4 with a blood glucose check. R4's record included prescriber orders including "blood sugar checks QID [four times daily]" dated October 17, 2022, and "surrgical [sic] open toed boot - BID - put on surgical open toed boot shoe (right foot) every morning and take off at night. To be used with all weightbearing. Indicated For sore on Right baby toe", dated November 7, 2022. R4's medication administration record (MAR) for December 2022, indicated R4 received assistance with blood sugar checks four times daily, and open-toed surgical boot to right foot "every morning and take off at night" daily from December 5-28, 2022. R4's service plan dated October 10, 2022, indicated R4 received services to include assistance with shower, dressing/grooming, safety check, housekeeping, laundry, medication management, and toileting. R4's service plan did not include treatment services including assistance with blood glucose monitoring and use of an open-toed surgical boot. R4's Treatment Management Plan, dated October 10, 2022, addressed blood glucose monitoring, but lacked the following regarding the use of an open-toed surgical boot: -Identification of the person responsible for	01940		

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01940	Continued From page 45	01940		

monitoring any treatment supplies are ordered on a timely basis.
-Identification of the staff who are responsible for the treatment management tasks, including tasks delegated to unlicensed staff; and
-Procedure for staff to notify the nurse when there is a problem with any treatment management service.

On December 28, 2022, at 10:27 a.m., registered nurse (RN)-B stated they would include treatments such as blood glucose checks in the resident service plan.
-at 12:38 p.m., RN-B stated the surgical boot for R4 should have been on the service plan, and they would be updating the service plan to include the surgical boot.

The licensee's Treatment & Therapy Management Plan policy, dated August 1, 2021, indicated, "For each resident at [licensee] receiving management of ordered or prescribed treatments or therapy services, the facility will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident." The policy further indicated, "[Licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:
a. A statement of the type of services that will be provided
b. Documentation of specific resident instructions relating to the treatments or therapy administration
c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel
d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy

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01940	Continued From page 46 services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions." The policy further indicated, "The treatment or therapy management record must be current and updated when there are any changes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to develop a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from	02040		

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02040	Continued From page 47	02040		

harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).

The findings include:

On December 28, 2022, at approximately 11:10 a.m., survey staff requested the facility hazard vulnerability or safety risk assessment plan for review from the licensed assisted living director (LALD)-A. At approximately 3:15 p.m., while reviewing the documentation there was no evidence of the hazard vulnerability assessment and mitigation plan documentation to identify and address potential hazards and related mitigation on and around the property to protect memory care residents from harm.

On December 28, 2022, at approximately 3:30 p.m. during an interview, survey staff again asked the LALD-A for the facility's hazard vulnerability and mitigation assessment plan required by statutes to protect the memory care residents from harm. The LALD-A confirmed the finding and stated that they had not developed the required hazard vulnerability assessment. Survey staff discussed the findings and explained to the LALD-A that all potential safety risks or vulnerabilities on and around the property must be identified, assessed, mitigated, and

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02040	Continued From page 48 documented in the plan documentation to protect the memory care residents from harm. At approximately 3:45 p.m., the LALD-A acknowledged the findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and	02110		

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02110	Continued From page 49 efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to five of five residents (R1, R2, R3, R4, and R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, R3, R4, and R5 were admitted on May 16, 2017, December 13, 2021, October 1, 2021, October 10, 2022, and December 11, 2021, respectively. R1, R2, R3, R4, and R5's records lacked documentation they or their designated representatives received the required policies and procedures to be provided.	02110		

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02110	Continued From page 50 On December 28, 2022, at 3:00 p.m., registered nurse (RN)-B stated the licensee had created the required dementia care policies but had not provided them to any resident or resident's representative. The licensee's Assisted Living with Dementia Care Additional Required Policies policy, dated August 1, 2021, directed that the licensee with an Assisted Living with Dementia Care license provide the additional required polices to residents and residents' legal representatives at admission. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.	02170		

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02170	Continued From page 51 (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to develop an individualized activity plan for each resident based on their activity evaluation. Further, the licensee failed to include a selection of daily activities on the resident's activity service or care plan for two of two residents (R4, R5) who resided on the dementia care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	02170		

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02170	Continued From page 52 The findings include: The licensee had a current assisted living with dementia care (ALFDC) license. R4 had diagnoses including dementia. R4's record included an activity evaluation dated October 10, 2022, but lacked an individualized activity plan based on the activity evaluation. R4's service plan, dated October 10, 2022, lacked a selection of daily structured and non-structured activities. R5 had diagnoses including dementia. R5's record lacked the development of an individualized activity plan and any evidence R5 was evaluated for activities according to the licensing rules of the facility to include the following: - past and current interests - current abilities and skills -emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions R5's service plan, dated October 17, 2022, lacked a selection of daily structured and non-structured activities On December 28, 2022, at 12:28 p.m., activities coordinator (AC)-F stated they often did not receive the activity assessments back from the resident or their family. AC-F stated she would personally interview the resident, but did not	02170		

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02170	Continued From page 53	02170		

document the findings. AC-F indicated there were approximately two move-ins per month, so, "you just remember" their interests.

On December 28, 2022, at 12:35 p.m., memory care activities coordinator (AC)-G stated if the activity evaluation was filled out, they would review it, and meet with the resident and their family to get to know them and their interests. AC-G stated the evaluation is filed and they would try to incorporate the residents' interests into their group activity schedule. AC-G indicated the unlicensed nursing staff was familiar with the residents, so should be familiar with their interests and likes and dislikes.

The licensee's ALDC Life Enrichment Programs, Activities & Outdoor Space policy, dated August 1, 2021, indicated, "An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs." and "A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate."

No further information provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Construction
Date: *12/27/22*
Time: 09:30:00
Report: 1031221235

Food and Beverage Establishment Inspection Report

Location:
The Shores Of Lake Phalen
1870 East Shore Drive
Maplewood, MN55109
Ramsey County, 62

Establishment Info:
ID #: 0038066
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517777784
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking
3-501.17A ***** Priority 2 *****

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

CHILI AND HAM FOUND IN PREP COOLER ON COOK LINE DATE MARKED PAST 7 DAYS. ***ITEMS DISCARDED*** COMPLY WITH ABOVE RULE.

Comply By: 12/27/22

4-600 Cleaning Equipment and Utensils
4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

BLENDER, SMALL MIXER, AND CAN OPENER FOUND WITH FOOD DEBRIS ON/AROUND EQUIPMENT. CLEAN AND MAINTAIN CLEAN ALL FOOD CONTACT AREAS.

Comply By: 12/30/22

4-100 Equipment Construction Materials
4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

MAT UNDER MICROWAVE ON COOK LINE IS NOT CLEANABLE. REMOVE MAT AND REPLACE WITH OPTION MEETING ABOVE REQUIREMENTS.

Comply By: 01/03/23

4-400 Equipment Location and Installation

4-402.11A

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.

REMOVE OLD SILICONE AROUND BACK AND SIDES ON 2-COMP SINK IN PREP AREA. RESILICONE USING 100% SILICONE.

Comply By: 01/10/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

SEE COMMENTS.....

Comply By: 01/10/23

4-500 Equipment Maintenance and Operation

4-502.11A

MN Rule 4626.0820A Maintain utensils and discard utensils that are not maintained in a state of repair.

2 SPATULAS AND 1 WHISK FOUND WITH MELTED AREAS MAKING UNCLEANABLE. 2 LADLES FOUND WITH BLACK STAINING. ALL ITEMS LISTED REMOVED FROM SERVICE. DISCARD ANY DAMAGED OR STAINED UTENSILS.

Comply By: 12/30/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

SEE COMMENTS.....

Comply By: 01/10/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = at 400 Degrees Fahrenheit
Location: Sanitizer Dispneser
Violation Issued: No

Quaternary Ammonia: = at 200 Degrees Fahrenheit
Location: Sanitizer Bucket (expo)
Violation Issued: No

Quaternary Ammonia: = at 200 Degrees Fahrenheit
Location: Sanitizer Bucket (dish area)
Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Milk
Temperature: 37 Degrees Fahrenheit - Location: Traulsen Cooler (expo)
Violation Issued: No

Process/Item: Cold Hold/Melon
Temperature: 38 Degrees Fahrenheit - Location: Traulsen Cooler (expo)
Violation Issued: No

Process/Item: Hot Hold/CK Noodle
Temperature: 153 Degrees Fahrenheit - Location: Soup Warmer (expo)
Violation Issued: No

Process/Item: Hot Hold/Sauerkraut
Temperature: 167 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Hot Hold/Beans
Temperature: 148 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Hot Hold/Turkey
Temperature: 153 Degrees Fahrenheit - Location: Steam Table
Violation Issued: No

Process/Item: Cooking/Hamburger
Temperature: 191 Degrees Fahrenheit - Location: Stovetop
Violation Issued: No

Process/Item: Cold Hold/Ham
Temperature: 41 Degrees Fahrenheit - Location: Prep Table Cooler (top)
Violation Issued: No

Process/Item: Cold Hold/Tomatoes; Sliced
Temperature: 41 Degrees Fahrenheit - Location: Prep Table Cooler (bottom)
Violation Issued: No

Process/Item: Cold Hold/Tomatoes; Diced
Temperature: 40 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Cold Hold/Lettuce
Temperature: 40 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	2	5

Inspection conducted by Chris F with MDH.

All violations discussed with Aaliyah during the inspection.

NOTES:

- Kitchen staff employed by Shores of Lake Phalen.

- Proper glove use and handwashing observed.

- Slicer in prep area on undershelf not being used

- Butter out is working stock only and discarded after 4 hrs or less.

4501-11AB
1. TWO PREP TABLE UNDERSHELVES IN PREP AREA ARE NOT ADJUSTED PROPERLY. REINSTALL SO UNDERSHELF IS AT OR ABOVE 6" FROM FLOOR.
2. WALK-IN FREEZER FLOOR IS BEGINNING TO DETATCH FROM UNDERLAYMENT. REPAIR OR REPLACE FLOOR PRIOR TO JAN 2024.

6-501.11
1. PREP AREA - REMOVE OLD HARDWARE AND SILICONE FROM WALLS AROUND 2-COMP SINK. FILL HOLES WITH 100% SILICONE.
2. COOK LINE - REMOVE OLD SILICONE AND BRACKET FROM WALL BEHIND PREP TABLE. FILL HOLES WITH 100% SILICONE. DO NOT REATTACH TO WALL; LEAVE LOOSE FOR CLEANING PER STAFF REQ.
3. MULTIPLE CEILING TILES NOT IN PLACE. READJUST ALL CEILING TILES SO ALL ARE PROPERLY SEATED IN GRID.
4. HOLE IN WALL ABOVE COVE BASE IN PREP AREA BY BLACK WARMING BOXES. REPAIR HOLE.
5. POSSIBLE LEAK FROM COPPER PIPE RUNNING UNDER 2-COMP SINK. REMOVE TOWELS AND REPAIR LEAK.

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

I acknowledge receipt of the Environmental Health inspection report number 1031221235 of 12/27/22.

Certified Food Protection Manager: Samantha R Mishler

Certification Number: FM105252 Expires: 02/08/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Aaliyah Sanders
Person in Charge

Signed: _____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031221235

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	2	Date	12/27/22
No. of Repeat RF/PHI Categories Out	0	Time In	09:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

The Shores Of Lake Phalen	Address: 1870 East Shore Drive	City/State: Maplewood, MN	Zip Code: 55109	Telephone: 6517777784
License/Permit #: 0038066	Permit Holder	Purpose of Inspection: Construction	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 12/27/22

Inspector (Signature)