DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 2, 2022

Administrator
Garden Court Chateau
2495 Southwest 8th Street
Grand Rapids, MN 55744

RE: Project Number(s) SL30596015

Dear Administrator:

On August 29, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 26, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

Electronically Delivered

June 22, 2022

Administrator
Garden Court Chateau
2495 Southwest 8th Street
Grand Rapids, MN 55744

RE: Project Number SL30596015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 26, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 218-332-5175| Fax: 218-332-5196

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN COURT CHATEAU	2495 SW 8TH STREET GRAND RAPIDS, MN 55744

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30596015 On May 23, 2022, through May 26, 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 19 residents, all of whom were receiving services under the provider's Assisted Living 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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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 May 23, 2022, at 10:40 a.m., during entrance conference, registered nurse (RN)-A identified licensed assisted living director (LALD)-B as being the LALD for the facility. On May 23, 2022, at 2:57 p.m., LALD-B identified herself as the LALD for the facility. LALD-B obtained an assisted living director license on July 7, 2021. On May 24, 2022, at 7:56 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-B held a	0 110		

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0 110	Continued From page 2 current assisted living director license. The BELTSS website did not indicate LALD-B as the Director of Record for the licensee. On May 24, 2022, at 3:16 p.m., RN-A confirmed LALD-B was not listed as the Director of Record for the licensee. RN-A stated she was not aware of the requirement for the Director of Record and would inform LALD-B of the requirement. The licensee's Assisted Living Director dated August 1, 2021, indicated the licensee would maintain a current and active license with BELTSS and would comply with all requirements set forth by BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or	0 250		

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0 250	Continued From page 3 misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements	0 250		

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0 250	Continued From page 4 of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 23, 2022, approximately 10:40 a.m. to 12:29 p.m., registered nurse (RN)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations. RN-A confirmed the licensee provided medication management and treatment services, completed resident reviews and monitoring, followed infection control practices, provided training and competency evaluations of staff. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section]	0 250		

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0 250	Continued From page 5 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult	0 250		

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0 250	Continued From page 6 Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by Co-Owner	0 250		

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0 250	Continued From page 7 (CO)-E on April 28, 2022. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were implemented: -competency evaluations of staff; -conducting initial and ongoing resident evaluations and assessments; -orientation and implementation of the assisted living bill of rights; - infection control practices; - medication management; -delegation of tasks by registered nurses or licensed health professionals; and -supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0110, 0470, 0485, 0510, 0550, 0630, 0640, 0650, 0680, 0780, 0800, 0810, 1440, 1620, 1760, 1880, 1890, 1950, 2350, and 3090, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470		

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0 470	Continued From page 8 least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and post a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all 19 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	0 470		

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0 470	Continued From page 9 or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The facility was licensed for a capacity of 24 and had a current census of 19 residents. On May 23, 2022, at approximately 11:05 a.m., during entrance conference, registered nurse (RN)-A identified herself as the clinical nurse specialist. The surveyor requested the licensee's staffing plan to review. RN-A stated she had not developed or implemented a staffing plan which was evaluated twice a year. On May 23, 2022, at approximately 3:10 p.m., during a facility tour licensed assisted living director (LALD)-B and RN-A confirmed the staff schedule was not posted as required. RN-A confirmed the dry erase board located on the side of the kitchen refrigerator was blank, and further stated the daily staff schedule should be written on the dry erase board daily and updated with any staff schedule changes. On May 24, 2022, at approximately 7:05 p.m., the dry erase board located on the kitchen refrigerator was dated for May 23, 2022, and did not have the staffing schedule posted. On May 25, at approximately 1:18 p.m., RN-G provided the licensee's contingency staff plan dated 2020, and stated she was informed from Co-Owner (CO)-E that was used as the licenses' staffing plan. The staffing contingency plan indicated it would be used in the event of an emergency or disaster, and included the following:	0 470		

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0 470	Continued From page 10 -delegation of authority; -critical function; and - minimum personnel required to maintain critical function. The document lacked indication as to how the staffing level was determined: -what were resident needs and how was resident acuity measured; -how the staff qualifications factored into determining staff level; and -what roles ancillary staff of the facility play in meeting residents' needs. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; -ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and -ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. The licensee's Staff and Scheduling policy dated August 1, 2021, indicated the licensee clinical nurse supervisor/DON would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven days a week. The licensee would post the work schedule daily at the beginning of every work shift in a central location in each building of a facility campus, accessible to staff, residents, volunteers, the public.	0 470		

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	30596	A. BUILDING: _____ B. WING _____	05/26/2022

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0 470	Continued From page 11 No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 470		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents.	0 485		

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0 485	Continued From page 12 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on May 23, 2022, at approximately 3:10 p.m., with licensed assisted living (LALD)-B and registered nurse (RN)-A, menus were not posted in the dining or main areas of the facility. LALD-B and RN-A confirmed menus were not printed or provided for the residents and were only located in the kitchen for the cook. The licensee's Food Service and Menu Planning policy dated August 1, 2021, indicated menus would be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and	0 510		

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0 510	Continued From page 13 Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 regarding wearing appropriate personal protective equipment (PPE). In addition, the licensee failed to ensure unlicensed personnel (ULP)-E disinfected equipment in between use. 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: The Minnesota Department of Health (MDH) guidance titled, COVID-19 Personal Protective Equipment (PPE) and Source Control Grids dated April 7, 2022, indicated health care workers working with residents with or without suspected or confirmed SARS-CoV-2 (Covid-19) wear a face mask and eye protection in communities with substantial and high community transmission levels.	0 510		

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0 510	Continued From page 14 WEARING PPE On May 23, 2022, at approximately 10:12 a.m., the surveyor entered the facility. There was a table inside the facility at entrance with hand sanitizer, a box of medical grade face masks, disinfecting wipes, an electronic thermometer, and a COVID-19 screening questionnaire. No signed was observed on what proper PPE was expected to be worn while in the facility or other COVID-19 related signage. While the surveyor was completing COVID-19 screening, three staff were observed not wearing eye protection or medical grade face masks. Registered nurse (RN)-A greeted the surveyor at entrance, not wearing a mask or eye protection. At approximately 10:40 a.m., during entrance conference, RN-A was not wearing a mask and wore regular eyeglasses. RN-A confirmed there were no active or presumptive COVID-19 residents or employees at the time of survey. RN-A stated the licensees did not require staff or visitors to follow CDC guidelines regarding PPE guidelines. RN-A named Co-Owner (CO)-E as the person who oversaw the infection control program. During the course of the survey, from May 23, 2022, through May 26, 2022, the surveyor observed the following: On May 24, 2022, at approximately 6:57 a.m., the surveyor observed ULP-J at the medication cart not wearing a mask or eye protection. ULP-J stated she worked from 11:00 p.m., to 7:00 a.m., shift and had direct contact with residents. ULP-J stated she usually wore a mask and the licensee left it up to the individual person to make that decision. -at approximately 7:08 a.m., the surveyor observed ULP-C working with residents and was	0 510		

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0 510	Continued From page 15	0 510		

not wearing a mask or eye protection.
On May 24, 2022, at approximately 12:39 p.m., the surveyor observed ULP-I wearing her medical grade mask below her nose and mouth, under her chin, while assisting R11 with a transfer into the bathroom. ULP-I stated wearing a mask and eye protection while working were optional and not required by the licensee.
-at approximately 4:32 p.m., the surveyor observed ULP-K not wearing a mask or eye protection, escorting R8 to the dining room and then continued to pass out beverages to residents in the dining room. ULP-K stated she was not sure if masks and eye protection were and actual requirement to wear while at work and further stated she was told by the licensee it was a personnel choice.

On May 25, 2022, at approximately 8:48 p.m., the surveyor observed ULP-L working in the kitchen, taking resident's breakfast orders not wearing a mask or eye protection. Right when ULP-L noticed the surveyor observing, ULP-L put on a face shield.
- at approximately 2:40 p.m., the surveyor observed LALD-B and maintenance (M)-D sitting in the common area not wearing masks or eye protection.

On May 26, 2022, at approximately 8:13 a.m., the surveyor observed ULP-I wearing a mask but no eye protection, escorting R8 to the shower room.
-at approximately 8:13 a.m., the surveyor observed ULP-C not wearing eye protection escorting a resident to the scale.

On May 25, 2022, at approximately 10:45 a.m., RN-A stated she was aware Minnesota was currently in a high transmission rate for COVID 19 and was aware of the current MDH and CDC

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0 510	Continued From page 16 guidelines with regards to PPE usage. RN-A stated staff should be wearing a medical grade mask and eye protection when providing direct resident care. RN-A stated she had sent out a group text to include the owners regarding Minnesota's high transmission rate, however, the response from the owners was that masks and eye protection were only recommendations by CDC and Minnesota Department of Health (MDH) and were not mandatory. On May 25, 2022, at approximately 1:11 p.m., during a phone conversation, CO-E stated it was everyone's responsibility to keep up on the latest CDC guidelines regarding the use of PPE. CO-E stated she followed Care Providers direction on what PPE was required. CO-E stated she was included in a text sent by RN-A regarding Minnesota being in the red indicating a high COVID-19 transmission rate and the CDC guidelines were for healthcare works to wear a mask and eye protections. CO-E stated she could not force her employees to wear masks and eye protection due to the fear of the employees quitting. DISINFECTING EQUIPMENT BETWEEN USE On May 24, 2022, at 12:39 p.m., the surveyor observed ULP-I and ULP-C transferred R11 from her wheelchair into the bathroom; using an EZ Stand (a mechanical device to aide in transfer of persons with limited weight bearing ability) and provided toileting assistance; ULP-C and ULP-I then transferred R6 into her recliner chair. The sling was removed from under R6 and ULP-C and ULP-I removed the EZ-Stand and placed it outside of R11's door in the hallway, without disinfecting the EZ-Stand after use. At approximately 1:54 p.m., ULP-C brought the EZ-Stand into R8's room and assisted with	0 510		

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0 510	Continued From page 17 transferring R8 to the bathroom. After the transfer was completed, ULP-C brought the EZ-Stand out of R8's room and placed it into the hallway without disinfecting the EZ-Stand. At approximately 2:12 p.m., ULP-C confirmed the EZ-Stand was not disinfected in between resident use and should have been wiped down with bleach disinfecting wipes. ULP-C stated there were no disinfecting wipes out at the time to wipe down the EZ-Stand and planned to wipe it down later. The licensees' Cleaning of Shared Medical Equipment policy dated September 1, 2021, indicated the licensee would implement and maintain processes to ensure all reusable resident care equipment would routinely be cleaned, and when appropriate, disinfected, before and after reuse to include mechanical lifts. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment	0 550		

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0 550	Continued From page 18 to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the facility posted required information about the facility's grievance procedure to contain all 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 23, 2022, at approximately 2:57 p.m., during a tour of the facility, registered nurse (RN)-A and licensed assisted living director (LALD)-B confirmed the licensee did not have the grievance procedure posting as required. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee would post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaints. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 550		

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0 550	Continued From page 19 (21) days	0 550		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of two residents (R2, R3) 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 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). The findings include:	0 630		

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0 630	Continued From page 20 R2 R2's diagnoses included dementia, traumatic brain injury, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and hypertension (high blood pressure). R2's Service Plan dated February 18, 2022, indicated R2 received services which included medication administration, bathing, grooming, dressing, toileting, transferring, housekeeping and laundry. R2's Vulnerability Assessment/Abuse Prevention Plan dated May 28, 2021, identified areas of vulnerability with interventions and lacked a review of the resident's susceptibility to be abused by another individual, including other vulnerable adults, potential risk of self-abuse and resident's risk of abusing other vulnerable adults. R3 R3's diagnoses included hypothyroidism (low thyroid levels, congested heart failure, type two diabetes, asthma, and hypertension (high blood pressure). R3's Service Plan dated January 31, 2022, indicated R3 received services which include medication administration, bathing, grooming, dressing, toileting, transferring, housekeeping and laundry. R3's Vulnerability Assessment/Abuse Prevention Plan dated July 11, 2021, identified areas of vulnerability with interventions and lacked a review of the resident's susceptibility to be abused by another individual, including other vulnerable adults, potential risk of self-abuse and resident's risk of abusing other vulnerable adults.	0 630		

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0 630	Continued From page 21 On May 24, 2022, at approximately 4:01 p.m., registered nurse (RN)-G confirmed R2 and R3's IAPP was not completely filled out and did not include the review of the resident's risk of abusing other vulnerable adults, risk to be abused by other individuals, including other The licensee's Individual Abuse Prevention Plan policy dated August 1, 2021, noted the IAPP would contain an individualized review or assessment of the person's susceptibility to abuse by another individual including other vulnerable adults, and the person's risk of abusing other vulnerable adults, and potential risk of self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

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0 640	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas to include contact information for Minnesota Adult Abuse Reporting Center (MAARC) in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 23, 2022, at approximately 2:57 p.m., during a tour of the facility, registered nurse (RN)-A and licensed assisted living director (LALD)-B confirmed the licensee did not have the required postings for MAARC's contact information posted in common areas and near telephones as required as they were unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records	0 650		

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0 650	Continued From page 23 (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee records contained the required content for one of two employees registered nurse (RN)-A with records reviewed.	0 650		

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0 650	Continued From page 24 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 finding include: RN-A had a hire date of January 21, 2018, under the comprehensive home care license, and began providing services under the licensee's Assisted Living license on August 1, 2021. RN-A's employee record contained a Staff Performance Appraisal form, dated September 9, 2020; however, lacked any recent documentation of annual performance review that identified areas of improvement needed and training needs. On May 25, 2022, at 3:53 p.m., RN-G verified RN-A's employee record did not contain an updated Staff Performance Appraisal and was last completed on September 9, 2020. On May 26, 2022, at 10:53 a.m., RN-G provided the surveyor RN-A's Staff Performance Appraisal form dated May 26, 2022, and verified it was completed that day. The licensee's Employee Records policy dated August 1, 2021, indicated the licensee's employee records would be kept up to date and would include documentation of annual performance reviews that identify areas of improvement needed and training needs.	0 650		

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	30596	A. BUILDING: _____ B. WING _____	05/26/2022

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0 650	Continued From page 25 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 680		

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0 680	Continued From page 26 review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 23, 2022, at approximately 10:50 a.m., the surveyor requested for the licensee's EPP to review. Registered nurse (RN)-A stated she was not aware the licensee had an EPP to provide to the surveyor and would inquire with licensed assisted living director (LALD)-B. On May 23, 2022, at approximately 3:12 p.m., a facility tour was conducted with LALD-B and RN-A. The surveyor did not observe signage posted or information regarding the licensee's EPP in the common areas of the facility. LALD-B stated there was no emergency preparedness manual she could provide to the surveyor and had emergency policies throughout the policy manuals. On May 25, 2022, at approximately 3:51 p.m., RN-G provided the surveyor with an Emergency Preparedness Risk Assessment and Planning Form dated May 25, 2022. RN-G verified LALD-B completed the Emergency Risk Assessment after	0 680		

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0 680	Continued From page 27 the surveyor entered the facility and requested to review the licensee's EPP on May 23, 2022. The licensee's Emergency Preparedness Risk Assessment identified five events (such as tornado/severe weather, behavior crisis, and emergency resuscitation) and scored each event based on probability. The licensee's Emergency Management Plan and Emergency Disaster revised July 9, 2021, lacked the following required content: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a thoroughly completed risk assessment; - a missing resident plan that was reviewed quarterly (last dated August 1, 2021); - arrangements/contracts to re-establish utility services; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracing staff and residents; - subsistence needs for staff and residents during an emergency; - evacuation plan; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites; - a communication plan that included:	0 680		

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0 680	Continued From page 28 - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On May 26, 2022, at 12:49 p.m., RN-A confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program as required. The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated the licensee would have in place an effective and compliant Emergency Preparedness Plan, which would be reviewed annually and contain four primary elements to included: -risk assessment and planning -policies and procedures -a communication plan -staff training and exercises/drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 780	Continued From page 29	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 780		

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0 780	Continued From page 30 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 May 24, 2022, between 10:30 a.m. and 12:00 p.m., survey staff toured the facility with maintenance (M)-D. During the facility tour, survey staff observed that smoke alarms were not installed in some hallway areas outside each separate sleeping area in the immediate vicinity of bedrooms. Distance between some of the hallway smoke alarms measured between twenty and forty feet. During the tour interview, M-D confirmed that smoke alarms were not installed in some areas of the hallways. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (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 provide the physical environment in a continuous state of good repair and operation	0 800		

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0 800	Continued From page 31 with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 24, 2022, between 10:30 a.m. and 12:00 p.m., survey staff toured the facility with maintenance (M)-D. During the facility tour, survey staff observed the following: 1. To release exit doors, a button located near the top of the door frame must be pushed. Due to the height of these buttons, some people would be unable to reach them and was noted as a safety concern. Additionally, the facility is licensed for assisted living and was operating with secure exits. 2. Septic tank lids were in place but several bolts on the lids were missing. M-D confirmed during the tour interview that a button must be pushed to release exit doors and that some bolts were missing from the septic tank lids. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810	Continued From page 32	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide the	0 810		

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0 810	Continued From page 33 required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 24, 2022, between 10:30 a.m. and 12:00 p.m., survey staff toured the facility with maintenance (M)-D. During the facility tour, it was observed that the posted evacuation map did not include the location and number of resident sleeping rooms. In an interview with M-D during the tour, they confirmed that the location and number of resident sleeping rooms were missing from the evacuation map. On May 24, 2022, at approximately 12:00 p.m., documents were provided for review. Documents were reviewed by survey staff on May 24, 2022, between 12:00 p.m. and 12:50 p.m. 1. The 10.07 Fire Policy dated 08/01/2021 was not developed for the facility location. The policy failed to include the identification of unique or unusual resident needs for movement or evacuation. 2. The Code Red Fire Plan references floor plans and maps, but these documents were not included within the plan. Exit doors were referenced but locations not identified in the plans. 3. The licensee failed to provide annual fire safety and evacuation training for residents. Documentation was requested by survey staff but	0 810		

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0 810	Continued From page 34 not provided. 4. The licensee failed to provide the required employee training frequency. Documentation was requested by survey staff but not provided. 5. The log for 2022 fire/evacuation drills was blank. During the facility tour with M-D, they explained that evacuation drills were not being completed. On May 24, 2022, at approximately 1:25 p.m., the registered nurse (RN)-A confirmed during an interview that the facility failed to provide the required content within the fire safety and evacuation plans. The RN-A confirmed that the training frequencies were not met. They further explained that residents are trained upon admission and that staff training for fire safety and evacuation had not been documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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	01440		

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01440	Continued From page 35 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 interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of one unlicensed personnel (ULP)-F with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on March 23, 2022, to provide direct care services to residents of the facility. ULP-F's employee record lacked documentation of a registered nurse (RN) supervising ULP-F performing a delegated task within 30 days of	01440		

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01440	Continued From page 36 beginning work with the licensee. The licensee's employee schedule dated May 9, through June 5, 2022, indicated ULP-F was scheduled to work 20 out of 28 days, and was trained to administer medication. On May 26, 2022, at approximately 1:18 p.m., RN-A stated she was unable to provide the surveyor with ULP-F 's 30-day supervision because it was not completed for ULP-F. RN-A stated she was aware of this requirement and did not know why it had not been completed. The licensee's undated Supervision of Licensed and Unlicensed Personnel indicated direct supervision of unlicensed staff performing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for the agency and has been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 37 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments and did not exceed 90 days for two of two residents (R2, R3) 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 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). The findings include: R2 R2's diagnoses included dementia, traumatic	01620		

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01620	Continued From page 38	01620		

brain injury, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and hypertension (high blood pressure).

R2's Service Plan dated February 18, 2022, indicated R2 received services including medication administration, bathing, grooming, dressing, toileting, transferring, housekeeping and laundry.

R2's record indicated the RN completed a 90-day Monitoring and Reassessment on January 21, 2022, and April 28, 2022, which exceeded 90 days from the previous completed assessment by seven days.

R3
R3's diagnoses included hypothyroidism (low thyroid levels, congested heart failure, type two diabetes, asthma, and hypertension (high blood pressure).

R3's Service Plan dated January 31, 2022, indicated R3 received services including medication administration, bathing, grooming, dressing, toileting, transferring, housekeeping and laundry.

R3's record indicated the RN completed a 90-day Monitoring and Reassessment on January 21, 2022, and April 28, 2022, which exceeded 90 days from the previous completed assessment by seven days.

The licensee's Assessments, Reviews, and Monitoring policy dated August 1, 2021, indicated resident monitoring and reviews must be conducted as needed based on changes in the needs of the resident and cannot exceed 90

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01620	Continued From page 39 calendar days from the date of the last review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 40 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included the required content for three of three residents (R2, R3, R10) 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), 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 May 23, 2022, during entrance conference registered nurse (RN)-A confirmed the service plan was a template and used for all residents. R2 R2's diagnoses included dementia, traumatic brain injury, chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and hypertension (high blood pressure). R2's Service Plan dated February 18, 2022, indicated R2 received services including medication administration, bathing, grooming, dressing, toileting, transferring, housekeeping and laundry; however, R2's service plan lacked the following required content: -a contingency that included the action to be taken if the scheduled services cannot be provided. R3	01650		

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01650	Continued From page 41 R3's diagnoses included hypothyroidism (low thyroid levels), congested heart failure, type two diabetes, asthma, and hypertension (high blood pressure). R3's Service Plan dated January 31, 2022, indicated R3 received services including medication administration, bathing, grooming, dressing, toileting, transferring, housekeeping and laundry; however, R3's service plan lacked the following required content: -a contingency that included the action to be taken if the scheduled services cannot be provided. R10 R10's diagnoses included diabetes, hearing loss, stage three chronic kidney disease, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), delusional disorder (a belief or altered reality), and cognitive dysfunction. R10's Service Plan dated May 10, 2022, indicated R10 recieved services including medicaiton administration, however R10's service plan lacked the following required content: - a contingency that included the action to be taken if the scheduled services cannot be provided. On May 24, 2022, at approximately 3:53 p.m., RN-A and RN-B confirmed the Service Plans did not include a specific contingency action plan and only included the definition of essential services. The licensee's Service Plan policy dated August 1. 2021, indicated the Service Plan would include a contingency plan to include, the action the licensee would take if the scheduled service	01650		

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01650	Continued From page 42 could not be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were documented after administration for two of two residents (R3, R10) observed during medication administration. 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	01760		

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01760	Continued From page 43 or has the potential to affect a large portion or all of the residents). The findings include: R3 R3's Service Plan dated January 31, 2022, indicated R3 received services including medication administration. On May 24, 2022, at approximately 7:44 a.m. unlicensed personnel (ULP)-C was observed to set up R3's medication for administration. ULP-C initialed R3's medication administration record (MAR) after placing medications in the medication cup and then ULP-C was observed administering R3's morning medications. R10 R10's Service Plan dated May 10, 2022, indicated R10 received services including medication administration. On May 24, 2022, at approximately 8:00 a.m., ULP was observed to set up R10's medications for administration. ULP-C again initialed R10's MAR after placing medications in the medication cup and then was observed administering R10's morning medications. ULP-C confirmed she documented on the MAR prior to administering R3's and R10's medication because that is how she had been trained by licensee's nurses. During a group interview on May 24, 2022, at approximately 3:16 p.m., RN-G and licensed practical nurse/supervisor (LPN/S) LPN/S-H stated staff were trained to sign the MAR after each medication was dispensed into the medication cup, and if the medication was not administered for any reason, to circle the initials	01760		

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01760	Continued From page 44 on the MAR and document why the medications were not administered. RN-A stated staff should initial the MAR after the medications were administered not before. RN-A, RN-G, and LPN-H, reviewed the Assisted Living Training and Competency Manual for Oral Medications which directed after administration of medications to document the administration of the medications on the MAR. RN-A confirmed the licensee's medication training and medication administration policies were not being followed as directed. The licensee's Medication and Treatment Record-Documentation and Refusal dated August 1, 2021, indicated documentation of medication/treatments/therapy administration would be completed by the person who performed the task immediately after the medication assistance/administration was completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerator maintained an acceptable	01880		

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01880	Continued From page 45 temperature to ensure the medications were stored according to manufacturer's recommendations. 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: On May 23, 2022, at approximately 1:30 p.m., the surveyor toured the medication storage room with registered nurse (RN)-A, including a review of the locked medication refrigerator. RN-A confirmed the current medication refrigerator temperature was 31 degrees Fahrenheit (F). RN-A stated the thermometer was placed too close to the freezer and that was the reason the temperature was reading 31 degrees F and staff were instructed to keep the thermometer on the lower shelf. RN-A stated temperatures for all refrigerators were monitored and recorded daily. The surveyor requested medication refrigerator logs for the past three months to review. On May 25. 2022, at approximately 4:28 p.m., RN-G provided recorded temperature logs for February, March, and May of 2022 and stated she was unable to find the temperature logs for April 2022. The surveyor reviewed the recorded temperature logs which were missing several entries for May and a few missing entries for February. In addition, there were several recorded temperatures below 36 degrees F which is out of the recommended temperature range of	01880		

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01880	Continued From page 46 36 degrees F-46 degrees F. RN-G confirmed the missing entries and recorded refrigerator temperatures which were below 36 degrees F. RN-G stated the concern of the temperatures falling below 36 degrees F would be the medications were at risk for freezing. On May 26, 2022, at approximately 8:45 a.m., the contents of the medication refrigerator were observed and verified with RN-G. The refrigerator contained the following medications: -two unopened Basaglar 100 units/milliliters (ml) insulin pens (a multiple dose shaped injector device for insulin administration), eight unopened Novolog 100 units/ml insulin pens and one unopened Lantus Solostar 100 units/ml insulin pens for resident (R)-4. -two unopened Novolog 100 units/ml insulin pens and seven unopened Levemir Flex Touch insulin pens for R3 The medication refrigerator temperature logs indicated the range of the medication refrigerator should be 36-46 degrees F and indicated the following: -February 2022, log contained 24 of a possible 28 temperatures recorded and 21 were below 36 degrees F. -March 2022, log indicated there were 13 temperatures below 36 degrees F. -May 2022, log contained 15 of a possible 25 temperatures recorded and 11 were below 36 degrees F. On May 26, 2022, at approximately 12:49 p.m., RN-A stated staff monitoring the medication refrigerator had been instructed to adjust the thermostat if the temperature was out of range and not to keep the thermometer near the freezer. RN-A stated she recently sent out	01880		

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01880	Continued From page 47 education to all staff on the proper position of the thermometer. RN-A confirmed temperatures below 36 degrees F had the potential to freeze the insulin being stored. RN-A stated she planned on disposing all the insulin that was stored in the medication refrigerator and order a new supply at the cost of the licensee. RN-A stated the licensee did not have a policy on monitoring medication refrigerator temperatures. The manufacture instructions for Basaglar KwikPen revised July 2021, directed to store unopened insulin pens in the refrigerator at 36 degrees F to 46 degrees F and further directed not to use Basaglar insulin if it had been frozen. The manufacture instructions for Novolog Flexpen revised September 2021, directed to store unopened insulin cartridges in the refrigerator at 36 degrees F to 46 degrees and do not freeze or use if it had been frozen. The manufacture instructions for Levemir FlexTouch revised September 2020, directed to store unopened insulin in the refrigerator at 36 degrees F to 46 degrees F and not to freeze. The licensee's Medication Storage policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 48	01890		
01890 SS=F	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 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 bearing the original prescription label with legible information including the expiration date for time sensitive medications for six of seven residents (R2, R4, R6, R7, R8, R22) and failed to monitor for expired medications for one of seven residents (R9). 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). Findings include: On May 9, 2022, at 10:14 a.m., the surveyor observed the medication cart with unlicensed personnel (ULP)-C. ULP-C observed and confirmed the following: ORIGINAL PRESCRIPTION LABEL AND/OR DATING OF TIME SENSITIVE MEDICATIONS	01890		

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01890	Continued From page 49 R2 R2's Albuterol inhaler (used to treat chronic obstructive pulmonary disease), lacked a date the inhaler had been opened and when the inhaler would expire. R4 R4's Novolog Flex insulin pen (a multi dose pen shaped injector device for insulin administration), lacked the date the insulin had been opened and when the insulin would expire. R6 R6's Ozempic injection pen (antidiabetic medication used for the treatment of type 2 diabetes and long-term weight management), lacked a date the injector had been opened and when the injector would expire. R6's Ventolin inhaler (used to prevent and treat wheezing and shortness of breath), lacked the inhaler had been opened and when the inhaler would expire. R6's Incruse inhaler (used to treat chronic obstructive pulmonary disease) did not have an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which the medication had been issued. In addition, the inhaler did not have a label which indicated the date the pen had been opened and when the pen would expire. R7 R7's Refresh Tears eye drop was observed not being stored in the original package, was without a label and was without a cap. R8 R8's opened bottle of Refresh Tears eye drop did not have a label which indicated the date the eye drop solution had been opened and when the	01890		

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01890	Continued From page 50 solution would expire. R22 R22's Advair Discus inhaler (used to treat chronic obstructive pulmonary disease), was without a prescription label and had the number "22" written on the inhaler. In addition, the inhaler lacked a date the inhaler had been opened and when the inhaler would expire. EXPIRED MEDICATION R9's opened bottle of Calcium, Magnesium and Zinc had expired June 2021. On May 24, 2022, at approximately 3:16 p.m., RN-A and RN-G confirmed insulin pens, eye drops, and inhalers should have an open and end date on time-sensitive medications. RN-A stated it was the responsibility of the licensed practical nurse (LPN) who worked the "three F" spot to go through the medication cart weekly looking for any discrepancies. RN-G stated it was everyone's responsibly who administers medications to make sure all medications are labeled and if an over-the-counter medication was brought in by family, the medication needs to be labeled with at least the residents name and room number. The manufacture instructions for Novolog Flexpen revised September 2021, directed to throw away all opened NovoLog® vials after 28 days, even if they still have insulin left in them. The manufacture instructions for Ozempic dated February 2022, directed to throw away all opened Ozempic after 56 days, even if it still has Ozempic left in it. The manufacture instructions for Incruse inhaler	01890		

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01890	Continued From page 51 revised June 2019, directed to throw away 30 days six weeks after opened. The manufacture instructions for Advair Diskus revised August 2020, directed to throw away 30 days after opening foiled pouch. The licensee's Medication Storage policy dated August 1, 2021, indicated medications would be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and	01950		

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01950	Continued From page 52 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure specific written instructions for each resident were documented in one of one resident's record (R3) who received blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 23, 2022, at approximately 10:40 a.m., during entrance conference, registered nurse (RN)-A confirmed the licensee provided blood glucose (sugar) monitoring. R3's diagnoses included type two diabetes, hypothyroidism (low thyroid levels, congested heart failure, asthma, and hypertension (high blood pressure). R3's Service Plan dated January 31, 2022, indicated R3 received services which include medication administration, bathing, grooming, dressing, toileting, transferring, housekeeping and laundry. R3's Service Plan indicated R3 received treatments but did not indicate the type of treatments being provided by the licensee.	01950		

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GARDEN COURT CHATEAU	2495 SW 8TH STREET GRAND RAPIDS, MN 55744

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01950	Continued From page 53 R3's prescriber orders dated April 8, 2022, directed R3's blood sugar monitoring to be completed before each meal and at bedtime. R3's Treatment/Therapy Management Plan dated May 28, 2021, indicated R3's specific parameters regarding treatments would be located on the Resident's Treatment Administration Record (TAR). R3's May 2022, Medication Administration Record (MAR) directed to check R3's blood sugar before each meal and at bedtime. R3's record lacked specific written instructions to include parameters for monitoring R3's blood glucose results. On May 24, 2022, at approximately 7:36 a.m., unlicensed personnel (ULP)-C was observed monitoring R3's blood glucose with the Dexcom machine (tracks your glucose levels continuously throughout the day and night) and administering R3's morning insulin. On May 25, 2022, at approximately 12:14 p.m., licensed practical nurse/supervisor (LPN/S)-H stated all residents who received blood sugar monitoring had a pink sheet with signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) with acceptable ranges identified for both. LPN/S-H confirmed R3 record lacked the pink informational sheets and lacked specific written parameters for monitoring R3's blood glucose and when to notify the nurse or prescriber. On May 26,2022, at approximately 1:04 p.m., RN-A confirmed unless the prescriber set specific blood sugar parameters, blood sugar parameters were indicted on the printed pink Hypoglycemia	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN COURT CHATEAU	2495 SW 8TH STREET GRAND RAPIDS, MN 55744

(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
01950	Continued From page 54 and Hyperglycemia information sheets in the residents TAR. RN-A confirmed the Hypoglycemia information sheet did not include when to notify the nurse or provider when a resident's blood sugar was out of range. The surveyor requested the licensee's policy for monitoring blood sugar and parameters and was provided Hypoglycemia and Hyperglycemia information sheets dated 1992. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect. This MN Requirement is not met as evidenced by: Based in observation, interview, and record review, the facility failed to ensure one of one resident (R10) was treated with dignity and respect when unlicensed personnel (ULP)-C administered treatments to R10 in a public setting. 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	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	05/26/2022

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02350	Continued From page 55 situation has occurred only occasionally). The findings include: R10's diagnoses included diabetes, hearing loss, stage three chronic kidney disease, schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), delusional disorder (a belief or altered reality), and cognitive dysfunction. R10's Service Plan dated May 10, 2022, indicate R10 received services to include medication administration, and treatments. R10's Service Plan lacked a statement of treatments R10 received. R10's prescriber orders dated May 16, 2022, indicated R10's orders included Refresh tears (lubricant eye drops) one drop into both eye twice a day and blood sugar monitoring every morning before breakfast and as needed if difficult to arise. On May 24, 2022, at approximately 8:00 a.m., ULP-C was observed checking R10's blood sugar with the blood glucose monitoring machine and administering R10 her eye drops during breakfast in the dining room with other residents present. ULP-C stated it was her regular practice to check R10's blood sugar, administer her eye drops and medications during breakfast in the dining room. ULP-C stated she never asked if it bothered R10 to have her treatments administered in a public setting and never considered if it bothered the other residents. On May 24, 2022, at approximately 3:47 p.m., licensed practical nurse/supervisor (LPN/S)-H stated staff should not be administering any	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	05/26/2022

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02350	Continued From page 56 treatments in a public setting and all treatments should be completed in a private area to maintain the resident's dignity. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02350		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	05/26/2022

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03090	Continued From page 57 The findings include: On May 23, 2022, at approximately 10:12 a.m., the surveyor entered the facility. There was no signage observed posted at entryway of the facility regarding electronic monitoring devices. On May 23, 2022, at approximately 2:50 p.m., registered nurse (RN)-A stated the licensee had video cameras in or around the facility. RN-A confirmed the licensee did not have signage posted in the main entryway of the facility regarding electronic monitoring and further stated the sign was taped outside of the entrance and it must had blown off. RN-A stated there was an electronic monitoring sign posted outside the door near the smoking area but visitors and not all staff used that door to enter the facility. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated the licensee would support electronic monitoring and signs would be installed at each facility entrance assessable to visitors that state, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/23/22*
Time: 11:23:16
Report: 7939221107

Food and Beverage Establishment Inspection Report

Location:
Garden Court Chateau
2495 Sw 8th Street
Grand Rapids, MN55744
Itasca County, 31

Establishment Info:
ID #: 0038351
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189995999
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at >160F Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: TURKEY GRAVY
Temperature: 181 Degrees Fahrenheit - Location: WARMER
Violation Issued: No

Process/Item: POTATO SALAD
Temperature: 39 Degrees Fahrenheit - Location: 2 DOOR FRIGE
Violation Issued: No

Process/Item: BUTTER
Temperature: 38 Degrees Fahrenheit - Location: BACK ROOM FRIDGE
Violation Issued: No

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

DISCUSSION
HAND WASHING AND GLOVE USE

MONITORING WARE WASH MACHINE AND RECORDING TEMPERATURES.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH inspection report number 7939221107 of 05/23/22.

Certified Food Protection Manager: WANDA RAITER

Certification Number: FM97349 Expires: 02/09/25

Inspection report reviewed with person in charge and emailed.

Signed: NA

SHELIA
COOK

Signed:

RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us