DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 12, 2022

Administrator
Autumn Grace Ii
110 Raven Court
Mankato, MN 56001

RE: Project Number(s) SL23858015

Dear Administrator:

On April 5, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the January 13, 2022, evaluation were corrected. The 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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

February 15, 2022

Administrator
Autumn Grace II
110 Raven Court
Mankato, MN 56001

RE: Project Number(s) SL23858015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on January 13, 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 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23858	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GRACE II	110 RAVEN COURT MANKATO, MN 56001

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL23858015 On January 10, 2022, through January 13, 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 11 residents receiving services under the assisted living with dementia care license. On January 11, 2022, an immediate correction order was issued for SL23858015, tag identification 2310. On January 12, 2022, the immediate correction order, tag identification 2310, identified on January 11, 2022, was corrected. No further action required.	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.	
0 250 SS=F	144G.20 Subdivision 1. Conditions	0 250		

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0 250	Continued From page 1 (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 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;	0 250		

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0 250	Continued From page 2 (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 ensure the management officials who were in charge of the day-to-day operations and responsible for the resident's assisted living services, understood all of the assisted living facility with dementia care regulations. This had the potential to affect all 11 current 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 January 10, 2022, at approximately 12:49 p.m., licensed assisted living director (LALD)-B confirmed she was responsible for and participated in the	0 250		

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0 250	Continued From page 3 day-to-day operations. LALD-A stated she was familiar with the Assisted Living with Dementia Care licensing rules. The licensee had attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application and had developed required policies. The following orders were issued: Refer to licensing order at Statute 144G.41, Subd 1. The licensee failed to develop a staffing plan as required. Refer to licensing order at Statute 144G.41, Subd 1. The licensee failed to comply with Minnesota Food Code, chapter 4626. Refer to licensing order at Statute 144G.41, Subd 7. The licensee failed to post information for grievances and reporting of maltreatment. (Lacked policy). Refer to licensing order at Statute 144G.42, Subd. 1. The licensee failed to post the original, current license at the main entrance of the assisted living facility. (Lacked policy). Refer to licensing order at Statute 144G.42, Subd 10. The licensee failed to develop all requirements for disaster planning and emergency preparedness plan. (Lacked policy). Refer to licensing order at Statute 144G.45, Subd 2. The licensee failed to provide required employee training on fire safety and evacuation; failed to provide training on fire safety and evacuation to residents capable of self-evacuation; and failed to complete required employee evacuation drills.	0 250		

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0 250	Continued From page 4 Refer to licensing order at Statute 144G.50, Subd 3. The licensee failed to ensure all residents were provided the opportunity to designate a representative, as required. (Lacked policy). Refer to licensing order at Statute 144G.63, Subd 2. The licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations, as required. (Lacked updated policy). Refer to licensing order at Statute 144G.70, Subd 2. The licensee failed to ensure the registered nurse completed assessments of all residents at the frequency required. (Lacked policy). Refer to licensing order at Statute 144G.71, Subd 2. The licensee failed to ensure the RN completed face-to-face medication management assessments for all residents receiving medication management services. (Lacked updated policy). Refer to licensing order at Statute 144G.71, Subd 8. The licensee failed to ensure medications were administered as prescribed. Refer to licensing order at Statute 144G.71, Subd 20. The licensee failed to ensure time sensitive medications were dated when opened and with expiration. (Lacked direction in policy). Refer to licensing order at Statute 144G.72, Subd 3. The licensee failed to develop and maintain an individualized therapy management plan for all residents receiving treatments and/or therapies. Refer to licensing order at Statute 144G.81, Subd 1. The licensee failed to provide a hazard	0 250		

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0 250	Continued From page 5 vulnerability or safety risk assessment. Refer to licensing order at Statute 144G.82, Subd 3. The licensee failed to develop and implement all policies and procedures required for assisted living facilities with dementia care. Refer to licensing order at Statute 144G.84. The licensee failed to evaluate, develop, and implement an activity plan for all residents. Refer to licensing order at Statute 144G.91, Subd 4. The licensee failed to ensure side rails were assessed for appropriateness and safety, and risks versus benefits provided to residents/representative. Seventeen (17) correction orders were issued and numerous required policies for the updated statutes were lacking, which indicated the licensee's understanding of the Minnesota statutes and Rules were limited for compliance with sections 144G.08 to 144G.9999. 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 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	0 470		

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0 470	Continued From page 6 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 a staffing plan to meet the needs of all residents, and also failed to post its daily staffing schedule in a central location accessible to staff, residents, volunteers and the public. This had the potential to affect all 11 current 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).	0 470		

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0 470	Continued From page 7 The findings include: Staffing Plan The licensee's assisted living facility is on a cul-de-sac, or dead end, of a street, where two buildings are located, separated by parking lot, approximately 50 feet wide. One building on the property is called "Autumn Grace II" (the license being surveyed); and the other "Autumn Grace I." During the entrance conference on January 10, 2022, at approximately 1:45 p.m., executive director/licensed assisted living director/LALD-B stated the facility (Autumn Grace II) was staffed with two persons each day and evening shift: a "med tech" (an unlicensed staff, trained to administer medications) and "one aide." During the night shift, the building was staffed with one "med tech" and if extra help was needed, staff were directed to call to the other building (Autumn Grace I) and have one of the staff come over to assist. On January 11, 2022, at approximately 7:03 a.m., unlicensed staff (ULP)-D stated he worked night shifts and was the only person scheduled in the building (Autumn Grace 2). ULP-D verified that when additional staff were needed, he called over to the other building, (Autumn Grace I) which had two people working at night, because "they have more residents to take care of." ULP-D stated currently (at Autumn Grace II) there were two residents who required the assistance of two staff for transfers. ULP-D verified staff worked between both Autumn Grace I and Autumn Grace II, even though scheduled at one or the other. The licensee's document, "Direct Care Staffing Plan," undated, indicated adequate number of	0 470		

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0 470	Continued From page 8 staff is determined by current census of AGI (Autumn Grace I) and AG2 (Autumn Grace II) along with acuity of the residents. When a resident required assist of two, the 2nd RA (resident assistant) from AG1 or med tech would be the 2nd person to assist. On January 13, 2022, at approximately 3:32 p.m., LALD-B verified one staff was scheduled in "Autumn Grace II" for the night shift, and if more help was needed, staff called over to "Autumn Grace I", which had two staff on at night. LALD-B verified each of the facilities were licensed separately, and staff went between each facility as needed. LALD-B did not know if the buildings were licensed as a campus, but thought staff could float between the two buildings as needed to meet resident needs. LALD-B expressed understanding that their two entities, Autumn Grace I and Autumn Grace II, were licensed individually, and that each facility had to also individually meet the needs of it's residents. LALD-B verified that based on how they were licensed, they were not meeting the assisted living with dementia care regulations. Staff Posting The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building.	0 470		

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0 470	Continued From page 9 During a tour of the facility on January 10, 2022, at approximately 2:20 p.m., the surveyor observed the main entry area and the resident common areas of the building. There was no staff schedule observed. The following day, on January 11, 2022, at approximately 10:45 a.m., unlicensed personnel (ULP)-E verified there was no posting of a staff schedule. The licensee's Direct-Care Staffing Plan & Daily Schedule policy, undated, indicated the licensee would have an implemented, written staffing plan that would provide qualified direct-care staff sufficient to meet the resident's needs. Further, the clinical nurse supervisor would develop a 24-hour daily schedule, and the daily schedule would be posted at the beginning of each shift. The policy lacked the licensee's facility name. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 10 (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 11 current residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 25, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 11 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 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 post information related to the grievance procedure, resident advocacy information, as well as information for reporting suspected maltreatment. This had the potential to affect all 11 residents, staff and visitors to 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked postings in a conspicuous location and disclosure of resident advocacy to include: -a posting with all required content of the licensee's grievance procedure to include the name and email contact information for the	0 550		

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0 550	Continued From page 12 individuals who were responsible for handling grievances; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and -number and contact information and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On January 10, 2022, at approximately 2:20 p.m., the surveyor and licensed assisted living director (LALD)-B toured the facility, which included observations of entryways, hallways, and common areas. The licensee lacked posted information as detailed above. On January 11, 2022, at approximately 10:46 a.m., unlicensed personnel (ULP)-E verified information about the Ombudsman was not posted, nor information about how to report abuse to the Minnesota Adult Abuse Reporting Center. ULP-E walked over to an unlocked cupboard located in a hallway at the far end of the building and retrieved a three ringed binder called "Public View Binder." The binder contained phone numbers and information about the Ombudsman and MAARC. ULP-E also verified there was no information in the binder or posted regarding a complaint process or how to make a complaint. ULP-E was unaware why the binder was stored where it was, out of sight, and thought it should be available, "where the residents can get at it." On January 12, 2022, at approximately 1:00 p.m., licensed assisted living director (LALD)-B confirmed the original license and other required disclosures were not posted in the assisted living building. LALD-B stated the postings, "should be	0 550		

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0 550	Continued From page 13 out there" including the license, information about reporting abuse, and information regarding the Ombudsman. LALD-B stated if the postitngs were not in place, "they were not there" and "we will fix that." Policies regarding required facility postings and disclosure of contact information for resident advocacy including Ombudsman, abuse reporting and complaint/grievance process of the licensee were requested, but none were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display its current assisted living license in the main entrance of the facility. This had the potential to affect all 11 current residents, staff and visitors to the facility. 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	0 570		

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0 570	Continued From page 14 the residents). The findings include: On January 10, 2022, at approximately 2:20 p.m., the surveyor and licensed assisted living director (LALD)-B toured the facility, which included observations of entryways, hallways, and common areas. The licensee lacked a posted facility license. On January 12, 2022, at approximately 1:00 p.m., LALD-B confirmed the original license and other required disclosures were not posted in the assisted living building. LALD-B stated the postings, "should be out there" including the license, information about reporting abuse and information regarding the Ombudsman. LALD-B stated if the postings were not in place, "they were not there" and "we will fix that." A policy regarding required displaying of a license or required postings in an assisted living facility was requested, but none was provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 570		
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	0 680		

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0 680	Continued From page 15 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 review, the licensee failed to have a written emergency preparedness plan with all required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all 11 residents receiving services under the assisted living with dementia care license, staff and any visitors to 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).	0 680		

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0 680	Continued From page 16 The findings include: During the entrance conference on January 10, 2022, at approximately 1:45 p.m. the surveyor made a request to the licensed assisted living director (LALD)-B to view the licensee's emergency preparedness plan, including the facility vulnerability assessment. LALD-B stated the licensee did have an emergency plan, but there was likely no one document that included the items requested, and the information was, "probably not all in one place" except for the policies and procedures. On January 10, 2022, at approximately 3:30 p.m., the surveyor made observations in the facility and did not observe signage posted or information regarding the licensee's emergency preparedness plan. The licensee's emergency plan was contained in a three-ringed binder and included the following: - organizational chart; - undated and incomplete hazard and vulnerability assessment tool, which was not customized to the licensee's location; - facility roster; - floor and escape plans; - numerous policies; and - generic instructions describing emergency plans, not detailed to the licensee's location. The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment (the assessment tool contained in the licensee's plan lacked any analysis of what vulnerabilities the licensed facility could potentially face); -description of the population served by licensee;	0 680		

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0 680	Continued From page 17 -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation (the plan addressed evacuation, but in generic, non-specific terms); -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other faculties (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On January 12, 2022, at approximately 3:37 p.m., LALD-B verified there was no completed emergency preparedness plan with all of the required informaton. Regarding the facility assessment, LALD-B stated she recalled looking at the assessment tool and acknowledged the facility assessment was something they would have to address and work on. LALD-B also verified the existing plan lacked any description of the residents served or a complete set of policies. LALD-B expressed understanding the policies needed would be based on the assessment, which "we do not have." The licensee's "Meridian Senior Living, Disaster preparedness" document, undated, indicated each establishment shall have a written plan for	0 680		

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0 680	Continued From page 18 protection of all persons in the event of disasters, for keeping persons in place, for evacuating persons to areas of refuge, and for evacuating persons from the building when necessary. The document provided direction for the development of an emergency plan but lacked specific information for the licensee's emergency plan needs. The document did not address posting of the emergency plan; and also, did not align with the requirement in Appendix Z (the state-adopted guidelines for emergency preparedness). A policy regarding developing and implementing an emergency preparedness plan that aligned with new assisted living license requirements, including Appendix Z, was requested, but none was provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 810		

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0 810	Continued From page 19 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, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training on fire safety and evacuation to residents capable of self-evacuation; and failed to complete required employee evacuation drills. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 810		

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0 810	Continued From page 20 a large portion or all of the residents). Findings include: A record review and interview were conducted on January 11, 2022, at approximately 9:45 a.m. with the executive director/licensed assisted living director (LALD)-B on the fire safety and evacuation plan, fire safety and evacuation training, and fire safety and evacuation drills for the facility. Record review of the fire safety and evacuation plan indicated that the plan did not have provisions for fire protection procedures necessary for residents or 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. Record review of the fire safety and evacuation training indicated that employees did not receive training twice per year after initial hire. A policy provided by LALD-B indicated that fire safety and evacuation training was to be provided employees annually. Record review of the fire safety and evacuation drills indicated that evacuation drills for employees had not been performed every other month as required. A policy provided by LALD-B indicated that fire drills were to be conducted periodically but made no reference to evacuation drills as required by statute. On a facility tour on January 6, 2022, between approximately 10:30 a.m. and 11:40 a.m. with LALD-B and facilities manager (FM)-C, it was observed that the there were not fire safety and	0 810		

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0 810	Continued From page 21 evacuation plans posted or readily available throughout the facility. This deficient condition was visually verified by LALD-B and FM-C, accompanying the surveyor on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=E	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated	0 950		

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0 950	Continued From page 22 representative. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to document on the assisted living contract that a resident declined to name a designated representative for two of three residents (R2, R4) 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: The licensee's assisted living contract contains required language that offers the resident opportunity to name a designated representative. On the contract is space to write down and list the designated contact chosen by the resident; and also present is a box for the resident to initial if the resident chooses not to name a representative. R2 R2's service plan dated December 30, 2021, indicated R2 received services to include medication administration, blood glucose monitoring, laundry and housekeeping. On January 11, 2022, at approximately 9:18 a.m., the surveyor observed ULP-E administer R2's morning medications. R2's admission agreement paperwork included	0 950		

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0 950	Continued From page 23 the "Right to Designate a Representative for Certain Purposes" form, with the required language. R2's "Resident Agreement, Assisted Living with Dementia Care," (the assisted living contract) dated and signed by the resident December 1, 2021, did not list a designated representative, and the box to initial, if resident declined to name a designated representative, was left blank. R4 R4's service plan dated December 1, 2021, indicated the resident received services to include medication administration, meals, assistance with activities of daily living and laundry and housekeeping services. On January 11, 2022, at approximately 8:13 a.m., the surveyor observed registered nurse (RN)-A deliver breakfast to R4 at table in the dining area. R4's admission agreement paperwork included a "Right to Designate A Representative for Certain Purposes" form, with the required language. However, R4's "Resident Agreement, Assisted Living with Dementia Care," dated and signed by the resident December 30, 2021, did not list a designated representative, and the box to initial if resident declined to name a designated representative, was left blank. On January 13, 2022, at approximately 10:12 a.m., licensed assisted living director (LALD)-B verified R2 and R4's admission paperwork lacked the name of a designated representative or an initial in the box to indicate they declined to name a representative. LALD-B stated residents are offered opportunity to name a representative during admission and receive the notice that they	0 950		

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0 950	Continued From page 24 can name a rep. LALD-B stated this was likely just missed and not completed during the admission process. LALD-B stated the box should either be initialed, or a representative named. A policy regarding designated representatives/providing residents opportunity to decline/identify a representative was requested, but none was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	01470		

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01470	Continued From page 25 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to the assisted living facility licensing	01470		

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01470	Continued From page 26	01470		

requirements and regulations for three of three employees, (registered nurse (RN)-A, unlicensed personnel (ULP)-D and ULP-E) with employee records reviewed. This had potential to affect all eleven (11) current residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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:

During the entrance conference on January 10, 2022, at approximately 10:47 a.m., licensed assisted living director (LALD)-B stated she was familiar with the statutes and regulations for assisting living. LALD-B verified they were licensed to provided assisted living with dementia care services, under the new regulations and license, effective August 1, 2021.

Training records for RN-A lacked evidence the employee was oriented to the new assisted living licensing requirements in the following areas:
-an overview of 144G statutes;
-introduction and review of all the provider's policies and procedures related to the provision of assisted living services under 144G statutes; and
-review of person-centered planning and care.

Training records for ULP-D and ULP-E lacked evidence the employees were oriented to the new assisted living licensing requirements in the following area:

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01470	Continued From page 27 -an overview of 144G statutes. RN-A RN-A started employment on June 5, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 10, 2022, at approximately 5:06 p.m., the surveyor observed RN-A provide direct care services and obtain a blood sugar from a resident. RN-A's employee training record lacked evidence the RN was oriented to the new assisting living facility requirements as detailed above. ULP-D ULP-D started employment on September 7, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 11, 2022, at approximately 7:17 a.m., the surveyor observed ULP-D assist a resident with toileting, dressing and with use of a mechanical standing lift. On January 11, 2022, at approximately 7:44 a.m., ULP-D stated he had annual training around the beginning of August. Although ULP-D could not recal the specific topics, ULP-D stated he thought it was about the "new regs." ULP-D's employee training records lacked evidence ULP-D was oriented to the new assisted living facility licensing regulations, including an overview of the 144G statutes. ULP-E	01470		

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01470	Continued From page 28 ULP-E was hired on November 1, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On January 11, 2022, between approximately 8:10 a.m. and 8:45 a.m., the surveyor observed ULP-E administer medications to four residents. On January 11, 2022, at approximately 9:50 a.m., ULP-E stated she had annual training at the start of August last year but was unsure of all the topics and whether it included any new regulations. ULP-E's employee training records lacked evidence or orientation to the new assisted living facility licensing regulations, including an overview of the 144G statutes. On January 12, 2022, at approximately 4:15 p.m., assisted living director (LALD)-B stated the staff that were hired prior August 1, 2021 should have had an orientation and were retrained on the new regulations. When the surveyor reviewed the licensee's checklist used, LALD-B acknowledged it lacked the topic of orientation to the new statutes (144G). LALD-B also verified RN-A's record lacked evidence she had received the new orientation on the law changes, and stated the training was for the unlicensed staff and the nurse, "got missed." The licensee's Assisted Living & Assisted Living with Memory Care Orientation-All Staff policy, dated August 1, 2021, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. The policy indicated orientation would include: an	01470		

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01470	Continued From page 29 overview of Minnesota's assisted living law; an introduction and review of agency policies and procedures; and principles of person-centered planning and service delivery and how they apply to direct support services. The policy did not specifically identify 144G statutes; also, the policy lacked the licensee's facility name. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an 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	01620		

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01620	Continued From page 30 resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse conducted on-going resident monitoring/reviews no more than 90 days from the last date of assessment for one of three residents (R1) 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: R1 was admitted for services on June 22, 2021, with diagnoses including congestive heart failure, chronic kidney disease, Type 2 diabetes, hyperlipidemia, anxiety and hypertension. On January 11, 2022, at approximately 6:57 a.m., unlicensed personnel (ULP)-D and ULP-E transferred R1 using a mechanical lift from the resident's recliner chair to the toilet. R1's record indicated the nurse conducted a quarterly nursing assessment September 13, 2021; there were no subsequent nursing assessments completed for R1. On January 12, 2022, at approximately 9:27 a.m., registered nurse (RN)-A verified the most recent	01620		

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01620	Continued From page 31 assessment in R1's chart was dated September 13, 2021, and R1 should have had a 90-day assessment, on or about December 12 or 13, 2021. The licensee's Initial and On-Gong Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy, undated, indicated nursing assessments were completed by a registered nurse based upon the required assessment schedule and as needed based upon resident condition. The policy directed ongoing assessments be completed periodically, but no less that every 90 days. The policy referenced a license type not congruent with the licensee's current license type. An updated policy regarding resident assessment under the new assisted living regulations was requested, but none was provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face	01700		

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01700	Continued From page 32 with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for three of three residents (R1, R2 and R4) 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 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:	01700		

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During the entrance conference on January 10, 2022, at approximately 1:33 p.m., registered nurse (RN)-A and licensed assisted living director (LALD)-B confirmed the licensee provided medication management services to all residents at the facility.

R1's, R2's and R4's records lacked evidence a registered nurse conducted an assessment for each resident to determine what medication management services would be provided and how they would be provided. The records lacked evidence of an assessment that included review of all medications the resident was known to be taking to include indications for use, side effects, contraindications, allergic or adverse reactions, and actions to address those issues. In addition, the residents' records failed to identify interventions needed in the management of medications to prevent diversion of medications by the resident or others who may have access to the medications.

R1
R1's diagnoses included congestive heart failure, chronic kidney disease, Type 2 diabetes, hyperlipidemia, anxiety and hypertension.

R1's prescriber's orders dated December 23, 2021, included the following medications: low dose aspirin, cholesterol-lowering medication, anti-platelet drug, drug to prevent angina (chest pane), diuretic, iron tablet, blood pressure medication, two types of insulin and nasal spray to treat allergy symptoms.

R1's service plan, dated June 22, 2021, indicated R1 received medication management services.

On January 11, 2022, at approximately 8:25 a.m.,

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01700	Continued From page 34 the surveyor observed unlicensed personnel (ULP)-E administer R1's morning medications. R1's record lacked evidence of a medication management assessment as detailed above. R2 R2's diagnoses included anxiety, chronic back pain, bronchitis, edema, esophageal reflux, hypothyroidism, diabetes, hyperlipidemia, atrial fibrillation and hypertension (high blood pressure). R2's service plan, dated December 1, 2021, indicated R2 received medication management services. R2's prescriber orders dated December 9, 2021, included the following medications: stool softener, bowel management medication, thyroid replacement, blood pressure medication, oral diabetic agents, anti-depressants, drug to treat gastric ulcer, blood thinner, cholesterol-lowering medication, drug to treat spasms, eye drops and two different types of insulin. On January 11, 2022, at approximately 9:18 a.m., the surveyor observed ULP-E administer R2's morning medications, which included insulin. R2's record lacked evidence of a medication management assessment as detailed above. R4 R4's diagnoses included Cerebral Palsy and depression. R4's service plan, dated December 30, 2021, indicated R4 received medication management services.	01700		

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R4's prescriber's orders dated December 30, 2021, included the following medications: anti-psychotic; stool regulator, drug to treat over-active bladder, mood stabilizer, anti-anxiety medication, drug to treat back spasm and dietary supplement.

On January 11, 2022, at approximately 8:13 a.m., the surveyor observed ULP-E administer R4's morning medications.

R4's record lacked evidence of a medication management assessment as detailed above.

On January 12, 2022, RN-A stated the only document she was familiar with was the resident's medication management plan. RN-A reviewed R1's assessments and verified there was no additional medication assessment completed that would have included a medication reconciliation, review of any side effects or allergic reactions and actions to address those or made an assessment of to identify possible diversion of drugs. RN-A stated she had only admitted one of the three residents listed and was sure she had not completed a medication assessment that included all elements. RN-A stated she believed no resident would have a documented medication management assessment in their record.

The licensee's Initial and On-going Nursing Assessment of Residents Under the Comprehensive Licensed Agency policy, undated, indicated nursing assessments were completed by a registered nurse based on the required assessment schedule and resident condition. The policy indicated a medication assessment included review of medications including over the

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01700	Continued From page 36 counter, prescriptions and supplements, and would include, but were not limited to: reason taken, side effects, contraindications, allergic or adverse reaction and actions to address these, dosage, frequency of use, route, resident difficulties taking medications, and medication management interventions to prevent drug diversion by the resident or others. The policy contained outdated language relevant to the new assisted living statutes contained in 144G. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as ordered for one of three	01760		

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residents (R2) 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:
R2's diagnoses included anxiety, chronic back pain, bronchitis, edema, esophageal reflux, hypothyroidism, diabetes, hyperlipidemia, atrial fibrillation and hypertension (high blood pressure).
R2's service plan, dated December 1, 2021, indicated R2 received medication management services.
R2's prescriber orders dated December 9, 2021, included the following medications: thyroid medication, diabetic insulin medications and diabetic oral medication (Metformin), anti-viral drug (Biktarvy), medication to treat esophageal reflux (omeprazole), blood thinner, blood pressure medication, anti-depressant, iron supplement and bowel management medications.
On January 11, 2022, at approximately 8:14 a.m., the surveyor observed R2 seated in a chair in the dining area eating breakfast.
At approximately 9:15 a.m., the surveyor observed unlicensed personnel (ULP)-E begin to set up R2's medications at the medication cart. Among R2's medications were Biktarvy and omeprazole. The pharmacy labels for Biktarvy and omeprazole each directed to administer the medication before meals.
At approximately 9:18 a.m., following breakfast, the surveor observed ULP-E administer R2's morning medications, which included Biktarvy

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01760	Continued From page 38 and omeprazole. On January 11, 2022, at approximately 9:31 a.m., ULP-E stated she typically did not work on this unit but added, "We do honor the time medications are supposed to be given", but acknowledged R2's pills were not given prior to the breakfast meal as ordered. ULP-E's training record indicated the ULP had been trained and demonstrated competency to administer medications, including oral medications, on January 31, 2020. On January 11, 2022, at approximately 2:23 p.m., registered nurse (RN)-A stated morning medications were usually administered around the time residents were out for breakfast, and she was unsure if there were residents who needed to have medications before meals. RN-A stated she expected staff give medications, "as they are ordered." The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy, dated August 1, 2021, indicated medications, treatment and therapy always need to be administered according the "6 rights" among which included "right time." The policy also indicated the RN may delegate administration of medications to unlicensed personnel when, the RN has communicated with the ULP about the individual needs of the client (resident) and the RN has documented that ULP have been trained and have demonstrated competency to follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

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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 time-sensitive medications were dated when opened for first use for two of two residents (R1, R2) who received insulin 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:
R1
R1's diagnoses included congestive heart failure, chronic kidney disease, Type 2 diabetes, hyperlipidemia, anxiety and hypertension.
R1's prescriber orders dated December 23, 2021, included two different types of insulin: Humalog and Lantus.
R1's service plan, dated June 22, 2021, indicated R1 received medication management services.
On January 11, 2022, at approximately 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's morning medications, which included Humalog Insulin. R1's Humalog insulin pen's prescription tag lacked a date

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opened when the pen was first used. On the tag was printed "Date Opened" along with a line upon which to write the date opened; it was blank.
On January 11, 2022, at approximately 8:30 a.m., ULP-E verified R1's insulin lacked the date opened. ULP-E said the staff person who first opens an insulin pen was responsible to write the date. ULP-E also verified R1's Lantus insulin pen's pharmacy label did not have the date opened written on it.
R2
R2's diagnoses included anxiety, chronic back pain, bronchitis, edema, esophageal reflux, hypothyroidism, diabetes, hyperlipidemia, atrial fibrillation and hypertension (high blood pressure).
R2's service plan, dated December 1, 2021, indicated R2 received medication management services.
R2's prescriber orders dated December 9, 2021, included two different types of insulin.
On January 11, 2022, at approximately 9:18 a.m., the surveyor observed ULP-E administer R2's morning medications, which included insulin. The surveyor observed R2's Novolog and Lantus insulins, neither of which was dated when opened. ULP-E stated the insulins should have been labeled and that was how staff were trained.
On January 12, 2022, at approximately 9:33 a.m., registered nurse (RN)-A stated once opened, an insulin pen was usually good for 28 days, some types longer. RN-A stated staff were trained to write down the date on the label when they opened a new insulin pen.
The licensee's Storage of Medications policy, dated August 2021, indicated medications would be handled and stored per acceptable standards. The policy did not specifically address the dating when opening of time-sensitive medication.
No further information was provided.

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01890	Continued From page 41 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced	01940		

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01940	Continued From page 42 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed a treatment management plan with all required content and specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of two residents (R1) who received blood glucose monitoring, 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: R1's individualized treatment or therapy management plans lacked documentation of the specific instructions relating to the blood sugar monitoring treatments provided and procedures for notifying a registered nurse or other licensed health professional should a problem arise with this treatment. Also, R1's treatment management plan lacked any mention R1 received the treatment of oxygen. R1's diagnoses included congestive heart failure, chronic kidney disease, Type 2 diabetes, hyperlipidemia, anxiety and hypertension. R2's prescriber orders also included oxygen, 1-2 liters per minute via nasal cannula, continuous, for shortness of breath, and keep 0-2 (oxygen) saturation greater than 90%. R1's prescriber's orders dated December 23, 2021, directed to test blood sugars before meals and at bedtime and as needed. On October 10, 2022, at approximately 4:38 p.m.,	01940		

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the surveyor observed R1 in his room, seated in a recliner, receiving oxygen via nasal cannula. The oxygen, flowing from a concentrator, was running at 3.5 liters per minute. Later, at approximately 5:06 p.m., they surveyor observed registered nurse (RN) enter R1's room to check R1's blood sugar.

On January 10, 2022, at approximately 5:08 p.m., R1 stated he gets short of breath and that's why he used oxygen. R1 sated he did not know if the staff checked oxygen use or what it was set at every day, but said staff, "put that thing on the end of my finger to test my oxygen." R1 admitted he sometimes changed the oxygen setting on his own. R1 also verified he takes insulin and that staff, "are supposed to check" his blood sugars before meals, but they were not always consistent.

R1's Treatment/Therapy Management Plan, dated June 22, 2021, indicated R1 was to have blood sugars/insulin before meals and at bedtime. There was no specific documentation of what blood sugar result may be either too high or too low, when to notify the nurse or physician, or what action was needed with abnormal results. There were no further instructions, parameters or directions related to blood sugar measurement.

R1's treatment plan lacked any mention of the oxygen treatment R1 received or further instructions, such as flow rate, checking/documentation of oxygen saturation, what problems to watch out for, or when to call the nurse should there be a problem with the delivery of the oxygen.

R1's Service Plan, dated June 22, 2021, also indicated R1 received blood sugar monitoring; there was no mention of a treatment for oxygen use.

R1's medication administration record (MAR) for January 2022 indicated R1 received blood sugar

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01940	Continued From page 44 monitoring four times daily. The MAR listed Oxygen Assistance and directed to apply oxygen as needed and per patient request; there were no more specific or further directions on the MAR related to R1's oxygen needs. On January 12, 2022, at approximately 9:25 a.m., RN-A stated R1's treatment of oxygen should have been on R1's treatment plan, and as well the flow rate, or when to check and his oxygen saturation. RN-A also stated there should be parameters listed regarding R1's blood sugars and instruction when to call a nurse. RN-A stated staff were trained to call if out of range but could not state what their policy indicated was out of range. The licensee's policy, Development of the Individualized Therapy/Treatment Plan, dated August 2021, indicated for each resident receiving management of ordered or prescribed treatments, the licensee would prepare and include in the service plan a written statement of the treatment services that will be provided. Further, the RN would develop the record for each resident, which included, but was not limited to a statement of the type of services that will be provided; documentation of specific resident instructions relating to the treatment or therapy administration, and procedures for notifying a registered nurse when a problem arises with a treatment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the	02040		

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02040	Continued From page 45 requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on January 11, 2022, at approximately 9:45 a.m. with the Executive Director/licensed assisted living director (LALD)-B on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around	02040		

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02040	Continued From page 46 the property. During interview, LALD-B stated the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and	02110		

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02110	Continued From page 47 intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed or implemented, and provided to each resident and/or the resident's legal and designated representative at the time of move-in. This had the potential to affect all 11 current, dementia-care residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 10, 2022, at approximately 12:49 p.m., the licensed assisted living director (LALD)-B verified the licensee held an assisted living facilitywith dementia care license.	02110		

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02110	Continued From page 48 The licensee failed to develop and implement policies and procedures that addressed: -philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; -evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; -wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; -medication management, including an assessment of residents for the use and effects of medication, including psychotropic medications; -staff training specific to dementia care; -description of life enrichment programs and how activities are implemented; -description of family support programs and efforts to keep the family engaged; -limiting the use of public address and intercom systems for emergencies and evacuation drills only; -transportation coordination and assistance to and from outside medication appointments; and -safekeeping of resident's possessions. On January 12, 2022, at approximately 10:09 a.m., LALD-B stated it was her understanding they had the required policies and procedures in place in preparation of the new licensure and also thought the polices were part of other exhibits presented and given to residents/representatives when then decided to live at the facility. LALD-B acknowledged there was no evidence the policies and procedures related to dementia care had been developed and provided to the residents or their representatives as required.	02110		

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02110	Continued From page 49 The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those	02170		

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that may help defuse a behavior;
(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;
(5) spiritual, creative, and intellectual activities;
(6) sensory stimulation activities;
(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and
(8) outdoor activities.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure residents were evaluated for activities according to the license of the facility, and activity plans were developed from those assessments for two of two residents (R1, R2) 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 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:

R1
R1's diagnoses included congestive heart failure, chronic kidney disease, Type 2 diabetes, hyperlipidemia, anxiety and hypertension.

On January 11, 2021, at approximately 1:41 p.m., the surveyor observed R1 in his room, seated in a recliner. When asked about activities in the assisted living facility, R1 stated there were

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activities offered, that he's been invited to Bingo and some singing and crafts but stated, "I've never participated." R1 stated he would like to get out of the building, but did not think that would be happening.

R1's record lacked evidence R1 had been evaluated for activities as described above and lacked the development of an individualized activity plan.

R2
R2's diagnoses included anxiety, chronic back pain, bronchitis, edema, esophageal reflux, hypothyroidism, diabetes, hyperlipidemia, atrial fibrillation and hypertension (high blood pressure).

On January 11, 2022, at approximately 8:14 a.m., the surveyor observed R2 seated in a chair in the dining area eating breakfast. Intermittently while eating and after eating, the surveyor observed R2 using a cell phone.

On January 11, 2022, at approximately 1:55 p.m., R2 stated he pretty much kept to himself, and when asked about activities to occupy time, R2 stated he "was not much" for activities. R2 also stated he didn't know if a lot going on at the facility interested him.

R2's record lacked evidence R2 had been evaluated for activities as described above and lacked the development of an individualized activity plan.

On January 13, 2022, at approximately 10:09 a.m., life enrichment coordinator (LEC)-G stated they used a screening tool or assessment to find out what resident preference were. LEC-G could

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02170	Continued From page 52 not say if all residents had been screened for activities and whether that screening was in each resident's plan. LEC-G stated R1 refused assessment and for some of the newer residents, screening had not been completed. LEC-G was unsure about the required activity evaluation for the new assisted living license and could not say if their current way of learning about resident interests and the tool they used met the guidelines. LEC-G also acknowledged there was no written or documented activity plan for residents, and that would be true for all the residents. A policy regarding resident assessment and development of an activity plan in the assisted living with dementia care licensed facility was requested, but none was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R4 and R2) who utilized bed rails with	02310	This immediate correction order identified on January 11, 2022, has been corrected as of January 12, 2022. This was confirmed by the surveyor's onsite observations and approved by evaluation	

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AUTUMN GRACE II	110 RAVEN COURT MANKATO, MN 56001

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02310	Continued From page 53 records reviewed. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 R4's diagnoses included cerebral palsy. On January 11, 2022, at 7:17 a.m., the surveyor observed R4 seated on a wheelchair in her room. R4's bed was equipped with bilateral bed rails. The bed rails were made from ten (10) vertical, metal tubes, each spaced approximately three (3) inches apart. The bed rails were rectangular-shaped, approximately three (3) feet wide and about eighteen (18) inches high. R4's bed rails were securely fastened to the bed frame and there was no gap on either side of the bed between the mattress and the rails. On January 11, 2021, at approximately 7:50 a.m., R4 stated she used the bed rails "Just to hang on." R4 stated she was unable to move much in bed and added that she cannot use the bed rail to change her position. R4 stated she thought the bed rail was to keep her from falling out of bed, and stated she had never done that. R4's record lacked any information regarding the bed rail use including assessment or indication R4 had previously used bed rails. R4's record lacked documentation the registered nurse (RN) discussed the appropriateness of the bed rail,	02310	supervisor. No further action required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23858	A. BUILDING: _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GRACE II	110 RAVEN COURT MANKATO, MN 56001

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02310	Continued From page 54 determination if the rail was safe for R4 to use, and the risks versus benefits of the bed rail. R4's vulnerability risk assessment dated December 31, 2021, lacked indication R4 utilized bed rails. R2 R2's diagnoses included Type 2 diabetes, anxiety, blindness of right eye, chronic pain and history of cardiovascular accident (stroke) with weakness on the left side. On January 11, 2022, at 9:18 a.m., the surveyor observed R2 seated on his bed in R2's apartment. R2's bed was equipped with bilateral bed rails. The bed rails were made from ten (10) vertical, metal tubes, each spaced about three (3) inches apart. The bed rails were rectangular-shaped, approximately three (3) feet wide and about eighteen (18) inches high. R2's bed rails were securely fastened to the bed frame and there was no gap on either side of the bed between the mattress and the rails. On January 11, 2021, at approximately 11:55 a.m., R2 stated he used the bed rail to reposition himself in bed and also to grab onto when he transferred himself into the wheelchair. R2's record lacked any information regarding the bed rails use including assessment or indication R4 had previously used bed rails. R2's record lacked documentation the RN discussed the appropriateness of the bed rail, determination if the bed rail was safe for R2 to use, and the risks versus benefits of the bed rail. R2's vulnerability risk assessment dated December 1, 2021, lacked indication R2 utilized	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23858	A. BUILDING: _____ B. WING _____	01/13/2022

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02310	Continued From page 55 bed rails. On January 11, 2022, at 2:40 p.m., registered nurse (RN)-A verified both R4 and R2 had bed rails. RN-A acknowledged there were "No additional assessments" for either resident regarding the use of bed rails and there was no mention of bed rail use in R4 and R2's vulnerability and risk assessments. RN-A stated she did not know if the risks versus benefits of bed rail use were discussed and were acknowledged by the resident and/or guardians. RN-A stated she did not complete the assessments or discuss the risks versus benefits; therefore, they were likely not done. The licensee's policy, Side Rails (Bed Rails) - Assistive Devices, updated February 15, 2020, indicated the resident, authorized responsible party, executive director, wellness director and others would be involved in the assessment and care planning process of the side (bed) rail use. If determined rails are necessary to meet resident's safety or mobility needs, the least restrictive device would be used as determined by the assessment and care planning process. Further, the resident and authorized responsible party would be educated by the community on the risk of use and complete the informed consent prior to use of the (bed) rails. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *01/25/22*
Time: 14:29:49
Report: 1028221018

Food and Beverage Establishment Inspection Report

Location:
Autumn Grace II
110 Raven Court
Mankato, MN56001
Blue Earth County, 07

Establishment Info:
ID #: 0018715
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
MS-AC Mankato AG Senior Living

Phone #: 5073880647
ID #: 46791

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

The following orders were issued during this inspection.

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

Discontinue filling the sanitizing at the handwashing sink in the kitchen area. Remove items from the around the sink to allow for easy access.

Comply By: 01/25/22

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

The cracked and damaged light shield in the back kitchen area must be replaced.

Comply By: 02/15/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Provide a handwashing poster at the handwashing stations in the kitchen and restroom areas.

Comply By: 01/25/22

Surface and Equipment Sanitizers

Food and Beverage Establishment Inspection Report

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: Wiping Cloth Bucket
Violation Issued: No

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: 3-Compartment Sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Chicken Salad
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Oatmeal
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -4 Degrees Fahrenheit - Location: Arctic Air - Ambient
Violation Issued: No

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

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221018 of 01/25/22.

Certified Food Protection Manager Ryan Wieneke

Certification Number: FM52916 Expires: 04/08/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ryan Wieneke
Kitchen Manager

Signed: _____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us