Electronically Delivered

April 26, 2024

Licensee
Landings Of Minnetonka
14505 Minnetonka Drive
Minnetonka, MN 55345

RE: Project Number(s) SL20107016

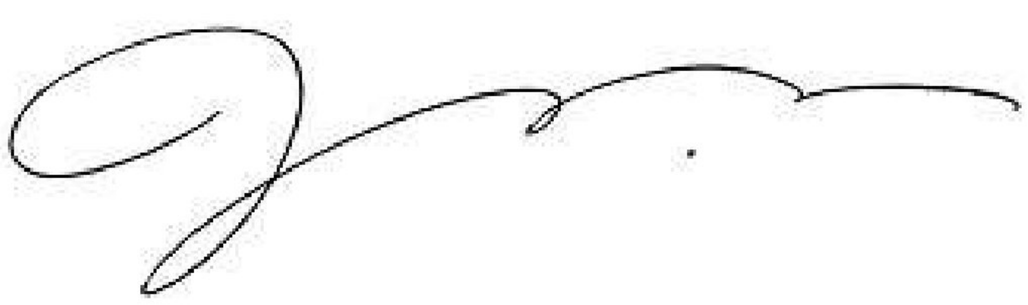
Dear Licensee:

On April 15, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 26, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

PMB

Electronically Delivered

February 9, 2024

Licensee
Landings of Minnetonka
14505 Minnetonka Drive
Minnetonka, MN 55345

RE: Project Number(s) SL20107016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 26, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF MINNETONKA	14505 MINNETONKA DRIVE MINNETONKA, MN 55345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20107016-0 On January 22, 2024, through January 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there 70 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (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 practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 23, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an infection control (IC) program that complies with accepted health care, medical and nursing standards for infection control for two of two biohazard bins and hand hygiene for one of two unlicensed personnel (ULP)-E. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: HAND HYGIENE On January 23, 2024, at 8:50 a.m., ULP-E obtained medications for R7 and R8 who shared an apartment and proceeded to their room. ULP-E entered R7 and R8's apartment with their respected medications each secured by a rubber band holding the medications bubble packs together. ULP-E entered the apartment and failed	0 510		

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0 510	Continued From page 3 to perform hand hygiene. ULP-E proceeded to pop out R7's medications into a medication cup (small paper cup commonly used to provide medications to people) and provided the medication cup and a cup of water to R7 to swallow their meds. ULP-E then proceeded to document the medications as given to R7 on the licensee's assigned tablet computer. ULP-E then completed the same steps for R8 without completing hand hygiene between the task of medication administration. Once ULP-E had completed medication administration for R8, ULP-E left R7 and R8's apartment without completing hand hygiene and proceeded to the licensee's medication room to return the bubble packs to the secured medication cart. ULP-E failed to perform hand hygiene once the medications were returned to the medication cart and proceeded to the common living area to interact with other residents and staff. On January 24, 2024, at 12:40 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated all staff should have completed hand hygiene between tasks. LALD/CNS-C stated ULP-E should have completed hand hygiene prior to entering R7 and R8's room, between medication administration, and once they left R7 and R8's room. The licensee's 8.09 Hand washing policy dated February 1, 2023, indicated hand hygiene would be completed between tasks and procedures. BIOHAZARD BIN On January 23, 2024, at 9:00 a.m., during a tour of the medication room, two red plastic biohazard sharps bins were noted to be in use. One was a commonly used five (5) quart red rectangular shape with a one-way safety flap for disposing of	0 510		

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0 510	Continued From page 4 needles or other items contaminated with human blood. The 5-quart bin was filled completely to the one-way flap and beyond the manufacture's identified, "full," line printed on the bin. The other was a six point nine (6.9) quart red rectangular bin with a round opening on top with plastic flaps to allow items to be placed inside and prevent return. The 6.9-quart bin had 4 exposed needles placed on top of the circular portion and not inside of the bin. An insulin syringe pen was place across the opening to the bin and not secured inside of the bin. On January 23, 2024, at 9:15 a.m., LALD/CNS-C stated all used or opened items that could have been contaminated with biohazardous waste should have been placed inside the biohazard sharps bins. LALD/CNS-C stated when biohazard sharps bin reached the "full," indicator, the bins should be locked and properly disposed of per manufacture's guidelines and licensee's policy and procedure. The licensee's 8.06 Disposal of Contaminated Materials policy dated February 1, 2023, indicated needles and syringes would be placed in designated sharps containers and read, "sharp's containers should never be filled more than ¾ full, then closed and disposed of per [licensee's] guidelines." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the	0 730		

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0 730	Continued From page 5 following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution;	0 730		

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0 730	Continued From page 6 (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain resident records with all required content related to provider orders for five of five residents (R2, R3, R4, R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 23, 2024, at 9:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C provided R2's requested record. LALD/CNS-C stated provider orders were being requested from the pharmacy. LALD/CNS-C stated the licensee reaches out to the pharmacy for access to signed provider orders as licensee would not be able to able to easily access current orders for any resident review requests. LALD/CNS-C stated the process was used for all resident who have orders from a provider. The licensee's 7.17 Medications & Treatment	0 730		

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0 730	Continued From page 7 Orders - Receiving policy dated February 1, 2023, indicated received orders would be immediately recorded and placed in the resident record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must	01060		

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01060	Continued From page 8 be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for two of two residents (R2, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 admitted to the licensee on November 21, 2023. R2's Progress Notes dated November 26, 2023, at 8:29 p.m. read, "resident was taken to the	01060		

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01060	Continued From page 9 hospital. No other updates at this time." R2's Progress Notes dated November 30, 2023, at 9:41 p.m. read, "Resident returned from the hospital." R2's record lacked documentation R2 or R2's designated representative received a written emergency relocation notice with all required content. R6 R6 admitted to the licensee on July 31, 2023. R6's Progress Notes dated January 14, 2024, at 9:12 p.m. read, "Writer sent resident to hospital." R6 Progress Notes dated January 18, 2024, at 5:18 p.m. read, "Resident returned back to the facility 01/18/2024." R6's record lacked documentation R6 or R6's designated representative received a written emergency relocation notice with all required content. On January 23, 2024, 11:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated no written emergency relocation notifications were provided to R2/R6 or R2/R6's designated representative. LALD/CNS-C stated the licensee thought the notification was only to be used when licensee was relocating someone based on services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01750	Continued From page 10	01750		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for one of five residents (R6) who received medication management. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on January 22, 2024, at 10:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the licensee provided medication	01750		

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01750	Continued From page 11 management services to residents at the facility. R6 admitted to the licensee on July 31, 2023. R6's diagnoses included diabetes mellitus. R6's service plan dated July 31, 2023, indicated R6 received services including medication administration. R6's prescriber orders dated August 25, 2023, included: -Novolog (fast-acting) FlexPen (insulin pen/a multiple dose pen shaped injector device used for insulin administration) 100 units/milliliter (mL) 10 units subcutaneously three times daily before a meal plus sliding scale, and -Novolog FlexPen 100 units/mL sliding scale: blood glucose <150=0 units, 150-199= 2 units, 200-249=4 units, 250-299=6 units, 300-349=8 units, 350-399=10 units, >400=12 units and call MD. Do not exceed 60 units per day. *Discard pen 28 days after first use, do not refrigerate after first use* R6's electronic medication administration record (EMAR) dated January 1, 2024, through January 23, 2024, included: -Novolog FlexPen 10 units subcutaneously three times daily before a meal plus sliding scale, and -Novolog FlexPen sliding scale: blood glucose <150=0 units, 150-199= 2 units, 200-249=4 units, 250-299=6 units, 300-349=8 units, 350-399=10 units, >400=12 units and call MD. Do not exceed 60 units per day. *Discard pen 28 days after first use, do not refrigerate after first use* On January 23, 2024, at 12:15 p.m., the surveyor observed unlicensed personnel (ULP)-D as they checked R6's blood glucose, which was 246. ULP-D performed hand hygiene, cleaned the tip	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20107	A. BUILDING: _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF MINNETONKA	14505 MINNETONKA DRIVE MINNETONKA, MN 55345

(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
01750	Continued From page 12 of the insulin pen with an alcohol wipe, applied needle, dialed the pen to 14 units, and gave the pen to R6 for self-injection. On January 23, 2024, at 12:25 p.m., ULP-D stated they were trained to prime the insulin pen (remove air bubbles from the needle, to ensure the needle is open and working) before insulin administration but forgot to complete this step and confirmed the EMAR did not contain instructions to prime the pen. On January 23, 2024, at 1:20 p.m., LALD/CNS-C stated they would expect the staff to prime the insulin pens before administration. LALD/CNS-C agreed there are no specific instructions in the EMAR that state to prime the insulin pen. LALD/CNS-C stated the pharmacy adds all the resident medications into the EMARs and they are unable to edit them, so all EMARs with insulin administration would be missing specific instructions to prime the insulin pen. The manufacturer's instructions for use of Novolog insulin injection dated March 2023, indicated before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air into ensure proper dosing: -Turn the dose selector to 2 units. -Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. -Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times. If you do not see a drop of insulin after six times, do not use the Novolog FlexPen.	01750		

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	20107	A. BUILDING: _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDINGS OF MINNETONKA	14505 MINNETONKA DRIVE MINNETONKA, MN 55345

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01750	Continued From page 13 The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated February 1, 2023, indicated prior to a ULP providing delegated medication administration and/or treatments/ therapy the following must occur: -A registered nurse right must specify, in writing, specific instructions for each resident and document those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored per the manufacturer's directions for all residents who had refrigerated medications. 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	01880		

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	20107	A. BUILDING: _____ B. WING _____	01/26/2024

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01880	Continued From page 14 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 23, 2024, at 9:00 a.m., during a tour of the medication room, two small refrigerators were stacked on each other and labeled, "Meds Only," on each door. The bottom refrigerator was opened, and puddles of water were noted at on the bottom of the refrigerator, but no medications were present. The surveyor opened the door to second refrigerator and noted multiple bags of insulin for multiple residents being stored. A chunk of ice was present and protruding from the bottom of the small freezer section and touching multiple bags of insulin. On the bottom of the refrigerator a puddle of water was present and leaking out on to the refrigerator below. No thermometer was noted to be in the refrigerator for temperature tracking and to ensure safe storage of the insulin present. On January 23, 2024, at 9:15 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated maintenance had been made aware of the water and ice in the refrigerator and had removed the thermometer from the refrigerator and placed the thermometer in another refrigerator to see of the thermometer was working correctly. On January 24, 2024, at 10:10 a.m., LALD/CNS-C stated pharmacy was contacted and provided the temperature logs and situation with water and ice. Pharmacy directed LALD/CNS-C that if the insulin was not wet and will continue to be maintained at the appropriate temperature, the insulin would be safe to continue to store and use as long as no more water and	01880		

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	20107	A. BUILDING: _____ B. WING _____	01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 15 ice was noted in the refrigerator. LALD/CNS-C stated staff who checked and documented temperatures failed to report the ice and water within a timely manner. The licensee's 7.11 Medication Storage policy dated February 1, 2023, indicated the licensee would store medications consistent with manufacturer's recommendations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=F	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	01940		

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	20107	A. BUILDING: _____ B. WING _____	01/26/2024

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01940	Continued From page 16 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management record to include all required content for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R6 was admitted on July 31, 2023. R6's Addendum A - Service Plan with effective date of July 31, 2023, indicated under Description of Services: Treatments was checked as a service provided but lacked identification of a treatment description. R6's Uniform Assessment Tool Form dated January 20, 2024, read under Individualized Treatment or Therapy Management Plan Form	01940		

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01940	Continued From page 17 section, "1. Statement of the type of services that will be provided (ordered or prescribed by a provider), and delegated to ULP (unlicensed personnel) L. Other: Lymphedema treatment through [3rd party home care company]." On January 24, 2024, at 10:30 a.m., R6 stated an occupational therapist from a home care company comes three times per week to wrap their legs. R6 stated wraps are occasionally wrapped by the licensee's ULPs. R6 stated when the licensee's ULPs wrap R6's legs with the lymphedema wrap they are often unraveling shortly after and present a tripping hazard for R6. On January 24, 2024, at 12:40 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated licensee had not developed an individualized treatment plan for R6's lymphedema wraps. LALD/CNS-C stated licensee's ULPs will occasionally help R6 with their wraps, but no orders, instructions, or documentation related to a treatment plan would be in R6's record. LALD/CNS-C stated licensee had not developed a treatment plan for any resident who had a treatment that was managed by a home care company. The licensee's 7.05 Treatment & Therapy Management Plan policy February 1, 2023, indicated licensee would develop an individualized treatment or therapy management record with all required content when a resident had a treatment or therapy service. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: *01/23/24*
Time: 10:00:00
Report: 1047241017

Food and Beverage Establishment Inspection Report

Location:
Landings Of Minnetonka
14505 Minnetonka Drive
Minnetonka, MN55345
Hennepin County, 27

Establishment Info:
ID #: 0037533
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529880011
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

DOORS ON VULCAN WARMING OVEN HAVE ENCRUSTED FOOD DEBRIS ON THE INSIDE OF THE DOORS. CLEAN & MAINTAIN CLEAN.

Comply By: 02/13/24

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

BACK KICKPLATE OF ICE MACHINE HAS BLACK & PINK SLIME BUILD UP. CLEAN & MAINTAIN CLEAN.

Comply By: 02/13/24

Type: Full
Date: *01/23/24*
Time: 10:00:00
Report: 1047241017
Landings Of Minnetonka

Food and Beverage Establishment Inspection Report

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

HANDWASH REMINDER SIGNS NOT PRESENT AT ALL HANDWASHING SINKS.

Comply By: 02/13/24

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit
Location: Dischmachine
Violation Issued: No

Acid: = 700 ppm at Degrees Fahrenheit
Location: 3 comp sink dispenser
Violation Issued: No

Acid: = 272 ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Arctic Air- beef
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Arctic Air- beef base
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: Prep cooler- roast beef
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Walk in- soup
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator B. Mueller.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

Type: Full
Date: *01/23/24*
Time: 10:00:00
Report: 1047241017
Landings Of Minnetonka

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1047241017 of 01/23/24.

Certified Food Protection Manager: Justin LaSalle Vonrueden

Certification Number: FM107930 Expires: 10/05/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Nasir Gabe
PIC

Signed: _____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us