Electronically Delivered

July 29, 2022

Administrator
CLGV Assisted Living Memory
5825 St. Croix Avenue North
Golden Valley, MN 55422

RE: Project Number SL30433015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 6, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30433	A. BUILDING: _____ B. WING _____	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLGV ASSISTED LIVING MEMORY	5825 ST. CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30433015 On July 5, 2022, through July 6, 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 12 residents, receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (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 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 ensure the required staffing plan was developed and posted as required, potentially affecting the licensee's current residents, staff and visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a client's health or	0 470		

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0 470	Continued From page 2 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 July 5, 2022, at approximately 10:30 a.m., during a tour of the facility, the surveyor did not observe the required posting of the staff schedule. 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. On July 5, 2022, at approximately 10:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-B confirmed a staffing plan had not been developed or a schedule posted as required. The licensee's undated Caregiver Daily Schedule policy indicated to always refer to the resident's individual plan of care for additional interventions but lacked verbiage to include staffing schedule. No further information was provided.	0 470		

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0 470	Continued From page 3 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: (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 adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents of the licensee. 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	0 480		

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0 480	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Report," dated July 5, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to implement and follow the Centers for Disease Control (CDC) and the Minnesota Department of Health (MDH) infection control guidance recommendations for eye protection for health care workers related to COVID-19. In addition, the licensee failed to ensure infection control practices were	0 510		

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0 510	Continued From page 5 maintained during medication administration and during meal service in the dining area. 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 client'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 clients). The findings include: On July 5, 2022, the BeReadyMN website indicated the licensee's county COVID-19 levels were at medium. On July 5, 2022, at approximately 10:35 a.m., during the facility tour, the surveyor observed unlicensed personnel (ULP)-C and ULP-E sitting with the residents without eye protection and their masks below their noses. On July 6, 2022, at approximately 8:30 a.m., ULP-E passed medication in the dining room with her mask below her nose and without eye protection. On July 6, 2022, at approximately 8:40 a.m., ULP-E did not sanitize her hands before and after medication administration and before going back into the medication cart and passing medication to the next resident. On July 6, 2022, at approximately 8:35 a.m., while serving breakfast, ULP-C took off gloves, pushed meal cart out of the way, and took a	0 510		

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0 510	Continued From page 6 resident's served plate for warming in the microwave. ULP-C then donned gloves to continue working. The Minnesota Department of Health COVID-19 PPE and Source Control Grids For Congregate Care Settings, by Community Transmission Level dated April 7, 2022, indicated staff should wear source control PPE when they are in areas of the health care facility where they could encounter residents. On July 6, 2022, at approximately 9:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-B acknowledged the observations and stated all employees are trained to observe infection control measures. The licensee's undated Staff Training policy indicated staff will be trained in infection control and standard precautions but did not include verbiage to include the use and procedures for personal protective equipment for infection control. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650		

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0 650	Continued From page 7 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for one of one employee (unlicensed personnel (ULP)-C) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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	0 650		

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0 650	Continued From page 8 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C started employment on March 26, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On July 6, 2022, during breakfast from approximately 8:30 a.m., through 9:30 a.m., ULP-C assisted residents in the dining room. ULP-C's record lacked evidence of annual training in the following: - Assisted living bill of rights, - infection control techniques (last completed on 12/26/2020) and - review of provider's policies and procedures. ULP-C's record lacked evidence of completed TB screening and training to include: - TB history and symptom screen - TB training (at hire and annually) On July 6, 2022, at approximately 2:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-B indicated she could not provide any further training documentation. The licensee's undated Resident Pre-Admission Appraisal policy indicated absence of TB must be evidenced by a physician report or chest x-ray but lacked verbiage for history and symptom screen and training. The licensee's undated Staff Training policy indicated direct care staff will receive initial orientation and ongoing in-service training based	0 650		

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0 650	Continued From page 9 on state regulations and the needs of the residents being served in the community to include missing content above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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0 810	Continued From page 10 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 document review and interview, the licensee failed to provide the required evacuation drill frequency. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 5, 2022, between 12:45 p.m. and 1:35 p.m., the licensed assisted living director (LALD)-B and the regional director of facilities management (RDFM)-F provided documents for review. Documents were reviewed by survey staff on July 5, 2022, between 12:45 p.m. and 2:00 p.m. Documentation was not included for evacuation drills completed between December 2021 and February 2022. The evacuation drill frequency of every other month was not met. On July 5, 2022, at approximately 2:10 p.m., the LALD-B confirmed during an interview that the licensee failed to provide documentation to support the evacuation drill frequency requirement.	0 810		

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0 810	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property for two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 started services with licensee on April 21,	0 970		

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	30433	A. BUILDING: _____ B. WING _____	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLGV ASSISTED LIVING MEMORY	5825 ST. CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

(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
0 970	Continued From page 12 2021. R2 started services with licensee on February 14, 2022. R1 and R2 's contracts dated August 1, 2021, and February 14, 2022, respectively, included waiver clauses in two section: - page 13 "The Corporation shall not be responsible for the loss of or any damage to any furniture, furnishings or other property belonging to Resident resulting from theft, water, fire or any other cause. The Corporation's insurance does not cover Resident's property. It is Resident's responsibility to obtain insurance for Resident's property. Resident and Corporation mutually waive their rights of subrogation against each other in the event of fire damage to property owned by the Corporation or by Resident." - page 13 indicated "Resident agrees to reimburse the Corporation for any loss or damage beyond normal wear and tear sustained by the Corporation as a result of willful acts, carelessness or negligence of Resident." On July 6, 2022, at approximately 11:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-B acknowledged the contract included a waiver and stated the same contract was used for all the licensee's residents. The licensee's undated Theft and Loss policy indicated the community is not responsible for lost or stolen items. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		

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01370	Continued From page 13	01370		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various	01370		

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01370	Continued From page 14 emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one employee (unlicensed personnel (ULP)-C) to include all required content with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on March 26, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On July 6, 2022, at approximately 8:20 a.m., ULP-C served breakfast to residents in the dining area. ULP-C's employee file lacked documentation of training and competency evaluations for the following topics: - documentation requirements for all services provided - reports of changes in the client's condition to the	01370		

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01370	Continued From page 15 supervisor designated by the home care provider - maintenance of a clean and safe environment - care and use of hearing aids - medication, exercise, and treatment reminders - basic nutrition, meal preparation, food safety, and assistance with eating - preparation of modified diets as ordered by a licensed health professional - understanding appropriate boundaries between staff and clients and the client's family - procedures to utilize in handling various emergency situations - awareness of commonly used health technology equipment and assistive devices On July 6, 2022, at approximately 11:30 a.m., licensed assistance living director/registered nurse (LALD/RN)-B acknowledged ULP-C's employee record lacked documentation of training and competency evaluation for the above topics as required. The licensee's undated Staff Training policy indicated each personnel record would include record of all required training and competency for unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	01380		

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01380	Continued From page 16 resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure training and competency evaluations were completed for all required skill areas prior to providing services for one of one unlicensed personnel ((ULP)-C) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on March 26, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021.	01380		

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01380	Continued From page 17 On July 6, 2022, at approximately 8:20 a.m., ULP-C served breakfast to residents in the dining area. ULP-C's employee file lacked documentation of training and competency evaluations for the following topics: - observation, reporting, and documenting of client status - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel - reading and recording temperature, pulse, and respirations of the client - recognizing physical, emotional, cognitive, and developmental needs of the client - range of motioning and positioning - administering medications or treatments as required - Other RN/professionally delegated tasks (e.g., monitor vital signs, catheter or stoma care, Broda chair, mechanical lifts) On July 6, 2022, at approximately 11:30 a.m., licensed assistance living director/registered nurse (LALD/RN)-B acknowledged ULP-C's employee record lacked documentation of training and competency evaluation for the above topics as required. The licensee's undated Staff Training policy indicated each personnel record would include record of all required training and competency for unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01380		

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01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations for one of one employee (unlicensed personnel (ULP)-C) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on March 26, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On July 6, 2022, at approximately 8:20 a.m.,	01460		

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01460	Continued From page 19 ULP-C served breakfast to residents in the dining area. ULP-C's employee file lacked orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents to include the following topics: - Overview of Home Care/Assisted Living statutes - Review of provider's policies and procedures - Handling emergencies and using emergency services - Reporting maltreatment of vulnerable adults or minors - Home care/Assisted Living bill of rights - Handling of resident/clients' complaints, reporting of complaints, where to report - Consumer advocacy services - Review of types of Home Care/Assisted Living services the employee will provide and provider's scope of license - Principles of person-centered planning/service delivery On July 6, 2022, at approximately 11:30 a.m., licensed assistance living director/registered nurse (LALD/RN)-B acknowledged ULP-C's employee record lacked orientation to assisted living facility licensing requirements and regulations as required. The licensee's undated Staff Training policy indicated each personnel record would include record of all required orientation to assisted living facility licensing requirements and regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01460		

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01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and/or representative to document agreement on the services to be provided for four of five residents (R1, R4, R5, R6) 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	01640		

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01640	Continued From page 21 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on November 2, 2018 R1's service plan dated April 13, 2022, signed by registered nurse (RN)-A indicated R1 was receiving services to include shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting, combing hair, transfers, and beauty shop. R1's service plan lacked a signature or other authentication by the resident and/or responsible party documenting agreement on the services to be provided. R4 R4 was admitted to the licensee on February 10, 2022. R4's service plan dated May 25, 2022, signed by RN-A indicated R4 was receiving services to include meal set up, shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting, grooming and reminders to use walker. R4's service plan lacked signature or other authentication by the resident or and/or responsible party documenting agreement on the services to be provided.	01640		

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01640	Continued From page 22 R5 R5 was admitted to the licensee on April 22, 2021. R5's service plan dated May 12, 2022, signed by RN-A indicated R5 was receiving services to include meals, shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting assist, grooming and reminders to use walker. R5's service plan lacked signature or other authentication by the resident and/or responsible party documenting agreement on the services to be provided. R6 R6 was admitted to the licensee on February 10, 2022. R6's service plan dated May 25, 2022, signed by the RN-A indicated R6 was receiving services to include meal set up, shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting, grooming and stand by assist transfers. R6's service plan lacked signature or other authentication by the resident and/or responsible party documenting agreement on the services to be provided. On July 6, 2022, at approximately 12:40 p.m., licensed assisted living director/RN (LALD)/RN-B acknowledged the service plans were missing signatures or other authentication by the residents and/or responsible parties documenting agreement on the services to be provided. LALD/RN-B further stated the licensee spoke with representatives to sign for them.	01640		

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01640	Continued From page 23 The licensee's undated Service Plan policy indicated the purpose of the service plan is to provide centralized coordination of services provided based on resident preferences, and should be signed by the resident and/or responsible party. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650		

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01650	Continued From page 24 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the service plan included the required content for five of five residents (R1, R2, R4, R5, R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on November 2, 2018. On July 6, 2022, at approximately 8:10 a.m., unlicensed personnel (ULP)-E administered morning medications to R1. R1's service plan dated April 13, 2022, indicated R1 was receiving services to include shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting, combing hair, transfers, and beauty shop.	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01650	Continued From page 25 R1's service plan lacked content to include: - a description of medication management services to be provided - the fees for services - the schedule and methods of monitoring staff providing services R2 R2 was admitted to the licensee on February 14, 2022. On July 6, 2022, at approximately 8:10 a.m., ULP-E administered morning medications to R2. R2's service plan dated February 14, 2022, indicated R2 was receiving services to include meals, shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, oral hygiene reminders, and redirection. R2's service plan lacked content to include: - a description of medication management services to be provided - the fees for services - the schedule and methods of monitoring staff providing services - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters R4 R4 was admitted to the licensee on February 10, 2022. On July 6, 2022, at approximately 8:10 a.m., ULP-C administered morning medications to R4. R4's service plan dated May 25, 2022, indicated R4 was receiving services to include meal set up,	01650		

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CLGV ASSISTED LIVING MEMORY	5825 ST. CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

(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
01650	Continued From page 26 shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting, grooming and reminders to use walker. R4's service plan lacked content to include: - a description of medication management services to be provided - the fees for services - the schedule and methods of monitoring staff providing services R5 R5 was admitted to the licensee on April 22, 2021. On July 6, 2022, at approximately 8:10 a.m., surveyor observed ULP-E administered morning medications to R5. R5's service plan dated May 12, 2022, indicated R5 was receiving services to include meals, shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting assist, grooming and reminders to use walker. R5's service plan lacked content to include: - a description of medication management services to be provided - a description of treatment and therapy services to be provided - the fees for services - the schedule and methods of monitoring staff providing services R6 R6 was admitted to the licensee on February 10, 2022. On July 6, 2022, at approximately 8:10 a.m., ULP-E administered morning medications to R5	01650		

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	30433	A. BUILDING: _____ B. WING _____	07/06/2022

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01650	Continued From page 27 in the dining room. R6's service plan dated May 25, 2022, indicated R6 was receiving services to include meal set up, shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting, grooming and stand by assist transfers. R6's service plan lacked content to include: - a description of medication management services to be provided - the fees for services - the schedule and methods of monitoring staff providing services On July 6, 2022, at approximately 12:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-B acknowledged the service plans were missing required content and stated the licensee used the same service plan for all residents. The licensee's undated Service Plan policy indicated a service plan would be created and maintained for every resident but lacked verbiage of the content to be included in a service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
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	01760		

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01760	Continued From page 28	01760		

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 medication was administered as ordered for one of one resident (R2) with record 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 was admitted to the licensee on February 14, 2022.

R2's diagnoses included posterior tibial tendinitis (pain of the foot and ankle), Alzheimer's Disease with late onset, and dementia without behavioral disturbance.

R2's service plan dated February 14, 2022, signed by registered nurse (RN)-A and licensed

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01760	Continued From page 29 assisted living director/registered nurse (LALD/RN)-B, did not indicate medication management as a service to be provided. R2's Individualized Medication Management Plan dated February 14, 2022 and reviewed on February 28, 2022, indicated unlicensed personnel (ULP) administer medications for R2. R2's physician orders dated February 21, 2022, included the following medications: - Anastrozole 1 milligram (mg) by mouth every day - gabapentin 100 mg capsule by mouth every day - simvastatin 40 mg tablet by mouth every day - fexofenadine 60 mg tablet by mouth as needed for allergy symptoms (runny nose, itchy eyes, and sneezing) - triamcinolone acetonide 0.1% topical cream two times a day as needed for itchiness R2's medication administration record (MAR) dated July 2022, lacked fexofenadine 60 mg tablet by mouth as needed for allergy symptoms. On July 6, 2022, at approximately 1:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-B acknowledged the medication was missing on the July MAR but could not explain how fexofenadine 60 mg was not listed and stated, "it must have been missed." The licensee's undated Medication Management policy indicated the medications are appropriately listed on the MAR, verifying accuracy according to physician orders. No further information was provided.	01760		

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01760	Continued From page 30 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R3) with record reviewed.	01910		

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01910	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was discharged from the licensee on March 28, 2022. R3's Service Plan dated December 17, 2021, indicated R3 received services which included meals, shower, bed making, linen change, personal laundry, house making, status check, dressing, wheelchair assist, toothbrush set up, and pull up and hygiene assist. R3's medication disposition record lacked the content to include medication strength. On July 6, 2022, at approximately 2:45 p.m., licensed assisted living director/registered nurse (LALD/RN)-B acknowledged discharge record was lacking the medication strength. The licensee's undated Medication Management policy indicated licensee will dispose in medication in in waste receptacles but lacked the content of the disposition record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		

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01930	Continued From page 32	01930		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures 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).	01930		

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01930	Continued From page 33 The findings include: During the entrance conference on July 5, 2022, at approximately 10:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-B stated the licensee provided treatment management services. On July 5, 2022, at approximately 11:00 a.m., LALD/RN-B confirmed the licensee failed to develop, implement, and maintain the following required policies: - written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, - educating and communicating with residents about treatments or therapies they are receiving; and - monitoring and evaluating the treatment or therapy - communicating with the prescriber. On July 6, 2022, at approximately 1:25 p.m., LALD/RN-C provided the surveyor with their policies and procedure manual but it lacked treatment or therapy management policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 34 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 by: Based on interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R5) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01940		

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01940	Continued From page 35 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: R5 was admitted to the licensee on April 22, 2021. On July 6, 2022, at approximately 7:45 a.m., unlicensed personnel (ULP)-C attempted to assist R5 put on TED stockings (antiembolism compression stockings), but R5 declined. R5's service plan dated May 12, 2022, indicated R5 was receiving services to include meals, shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting assist, grooming and reminders to use walker. R5's individual treatment management plan lacked content to include: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was	01940		

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01940	Continued From page 36 administered as prescribed, and - monitoring of treatment or therapy to prevent possible complications or adverse reactions. On July 6, at approximately 8:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-B acknowledged R5 did not have an individual treatment management plan and stated licensee will update R5's record to reflect the requirement. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for treatment of application of TED stockings for one of one resident (R5) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01970		

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01970	Continued From page 37 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: R5 was admitted to the licensee on April 22, 2021. On July 6, 2022, at approximately 7:45 a.m., unlicensed personnel (ULP)-C attempted to assist R5 put on TED stockings (antiembolism compression stockings), but R5 declined. R5's service plan dated May 12, 2022, indicated R5 was receiving services to include meals, shower, bedmaking, linen change, laundry, housekeeping, status check, dressing, toileting assist, grooming and reminders to use walker. R5's signed provider orders dated June 14, 2022, indicated R5 was prescribed bumetanide 2 milligram (mg) by mouth daily for fluid retention, and amlodipine 5 mg by mouth daily for hypertension. On July 6, at approximately 8:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-B acknowledged R5 did not have up-to-date written or electronically recorded orders from an authorized prescriber for all treatments and therapies. LALD/RN-B stated the licensee will contact the provider for current orders. No further information provided.	01970		

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01970	Continued From page 38 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that identified hazards on and around the property. Mitigation of hazards to protect residents from harm was not included. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	02040		

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02040	Continued From page 39 On July 5, 2022, between 11:30 a.m. and 12:30 p.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed an unlocked utility room that was not staffed. The utility room contained cleaning supplies and chemical storage. The sunroom contained an activity kitchen with a stove. On July 5, 2022, between 12:45 p.m. and 1:35 p.m., the licensed assisted living director (LALD)-B and the regional director of facilities management (RDFM)-F provided documents for review. Documents were reviewed by survey staff on July 5, 2022, between 12:45 p.m. and 2:00 p.m. The Hazard Vulnerability Assessment dated 04-22-22 did not include hazards or safety risks identified on and around the property. The property hazards had not been assessed and mitigated to protect residents from harm. On July 5, 2022, at approximately 2:10 p.m., the LALD-B confirmed during an interview that the licensee failed to identify hazards or safety risks on and around the property in the assessment. They also confirmed that mitigation of property hazards to protect residents from harm was not included. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies	02110		

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CLGV ASSISTED LIVING MEMORY	5825 ST. CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

(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
02110	Continued From page 40 (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 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	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30433	A. BUILDING: _____ B. WING _____	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLGV ASSISTED LIVING MEMORY	5825 ST. CROIX AVENUE NORTH GOLDEN VALLEY, MN 55422

(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
02110	Continued From page 41 licensee failed to ensure the required policies and procedures were provided to each resident and/or the resident's legal and designated representative at the time of move-in. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 6, 2022, at 11:00 a.m., the licensed assisted living director/registered nurse (LALD/RN)-B acknowledged the licensee lacked evidence the required policies and procedures related to the dementia care were provided to each resident and/or the resident's legal and designated representative. The licensee's undated Resident Pre-Admission Appraisal policy indicated the licensee will gather information on each potential resident to determine the need and type of services to be provided but lacked the verbiage to include the required policies and procedures related to the dementia care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training	02260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30433	A. BUILDING: _____ B. WING _____	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
02260	Continued From page 42 An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, an accurate description of the dementia care training program with the required content with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care license, dated August 1, 2021. During the entrance conference on July 5, 2022, at approximately 10:20 a.m., licensed assisted living director/registered nurse (LALD/RN)-B verified the licensee had a locked dementia unit. On July 6, 2022, at approximately 11:45 a.m., the surveyor requested a copy of the dementia	02260		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30433	A. BUILDING: _____ B. WING _____	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02260	Continued From page 43 training disclosure, but none was provided. On July 6, 2022, at approximately 12:30 p.m., LALD/RN-B acknowledged the licensee did not have a dementia training disclosure. The licensee's undated Dementia Care policy lacked information on the dementia disclosure content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *07/05/22*
Time: 11:26:36
Report: 7994221117

Food and Beverage Establishment Inspection Report

Location:
Clgv Assisted Living Memory
5825 St. Croix Avenue North
Golden Valley, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037914
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637321434
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A1 ** Priority 1 **

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

CHICKEN WAS COOKED THEN PLACED ON COUNTER BEFORE BEING PLACED IN HOT HOLDER WHERE IT SLACKED TO BELOW 135 F. STAFF REHEATED CHICKEN TO 167.

Comply By: 07/05/22

5-200A Plumbing: approved materials/design

5-202.12A ** Priority 2 **

MN Rule 4626.1050A Provide a handwashing sink equipped with running water at a temperature to permit handwashing for at least 15 seconds through a mixing valve or combination faucet.

FIRESIDE FOOD SERVICE AREA DOES NOT HAVE A HANDWASH SINK PRESENT. PROVIDE A HANDWASHING SINK FOR THIS AREA.

Comply By: 07/05/22

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

BASE COVING IN HERITAGE KITCHEN WAS INSTALLED INCORRECTLY ON TOP OF THE FLOOR TILES. CONTACT INSPECTOR WITH ANY QUESTIONS REGARDING REPLACEMENT.

Comply By: 07/05/23

Type: Full
Date: *07/05/22*
Time: 11:26:36
Report: 7994221117
Clgv Assisted Living Memory

Food and Beverage Establishment Inspection Report

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

THIS WAS AN UNANNOUNCED INSPECTION. I SPOKE WITH THE PERSON IN CHARGE ABOUT THIS REPORT AND ANY ITEMS WITHIN.

TEMPERATURES:
VEG 38
HAM 38

POTATO 158
SOUP 163
CHICKEN 134 **
CHICKEN 167

SANITIZERS:
DISHWASHER 170

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 7994221117 of 07/05/22.

Certified Food Protection Manager: Patricia Ellefson

Certification Number: 68091 Expires: 05/16/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994221117

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2	Date	07/05/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:26:36
Legal Authority MN Rules Chapter 4626		Time Out	

Clgv Assisted Living Memory	Address	City/State	Zip Code	Telephone
	5825 St. Croix Avenue North	Golden Valley, MN	55422	7637321434

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037914		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 07/05/22

Inspector (Signature) Crystal Elva