



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 22, 2024

Licensee
Push Services Inc.
4757 Louisiana Avenue North
Crystal, MN 55428

RE: Project Number(s) SL37222015

Dear Licensee:

On September 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 26, 2024, survey and the July 10, 2024, follow-up 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,

A handwritten signature in black ink that reads 'Kelly Thorson'.

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 31, 2024

Licensee
Push Services Inc
4757 Louisiana Avenue North
Crystal, MN 55428

RE: Project Number(s) SL37222015

Dear Licensee:

On July 10, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 26, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 26, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 26, 2024, found not corrected at the time of the July 10, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)
1880-Storage Of Medications-144g.71 Subd. 19 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on July 10, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on July 10, 2024, we identified the following violation(s):

0340-Correction Orders-144g.30 Subd. 5 - \$500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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.

IMPOSITION OF FINES:

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.

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.

A state correction 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.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna". The signature is fluid and cursive, with the first name "Tim" and last name "Hanna" clearly distinguishable.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37222	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 07/10/2024
NAME OF PROVIDER OR SUPPLIER PUSH SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4757 LOUISIANA AVENUE NORTH CRYSTAL, MN 55428		
(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL3722015-1 On July 10, 2024 the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 26, 2024. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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 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.		
{0 110} SS=C	144G.10 Subdivision 1a Assisted living director license required	{0 110}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: No further action required.	{0 110}			
0 340 SS=F	144G.30 Subd. 5 Correction orders a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed.	0 340			

Minnesota Department of Health

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0 340	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on April 26, 2024. 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 April 26, 2024, Minnesota Department of Health (MHD) issued the following citations: 0110, 0470, 0480, 0630, 0680, 0780, 0790, 0800, 0810, 0820, 1290, 1620, 1730, 1880, 1890 and 2310. On July 10, 2024, at 9:47 a.m., via cellular phone call, licensed assisted living director (LALD)-A stated the plan of correction (POC) was mostly completed and was currently working on it. LALD-A stated they were aware the POC had to be kept at the facility. The surveyor requested to see POC. LALD-A stated they were not near a computer and would take up to one hour and 30 minutes to email the POC. LALD-A stated they were out of the cities and could not come to the facility. On July 10, 2024, at 11:10 a.m., clinical nurse supervisor (CNS)-C stated they were unaware MHD had sent documentation to [licensee] and had not worked on the POC.	0 340			

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0 340	Continued From page 3 On July 10, 2024, at 11:17 a.m., the surveyor had not received a copy of the POC. On July 10, 2024, at 12:08 a.m., house manager (HM)-B stated staff was still in the process of completing the POC and was aware of the timeframe for each citation. On July 10, 2024, at 12:27 p.m., LALD-A arrived to the facility. On July 10, 2024, at 12:54 a.m., LALD-A presented an undated two-page document titled Push Services Inc Survey Corrections Health Field Identification (HFID)37222. The document indicated the [licensee] had corrected the following citations: 0110, 0470, 0480, 0630 and 0680. On July 10, 2024, at 1:00 p.m., LALD-A stated they had corrected the remaining citations but had not documented that on the POC. LALD-A stated they were not aware of each citation timeframe. LALD-A stated the reason for not completing the POC was the emailed survey results from MHD was in the email junk folder and did not discover the email until June 28, 2024. LALD-A stated they believed a hard copy would be mailed to [licensee]. LALD-A stated they could not show the email to the surveyor as it was already deleted. On July 10, 2024, at 1:50 p.m., CNS-C stated, "if it's not documented, it's not done." On July 11, 2024, at 10:42 a.m., the surveyor reviewed email correspondence between MHD Enforcement and [licensee]. The correspondence indicated MHD sent an email to [licensee] on May 28, 2024, at 1:56 p.m., titled Survey Results Push	0 340			

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0 340	Continued From page 4 Services Inc - Survey Results SL37222015. The email contained the following attached documentation: Enforcement Letter, State Form, and Food and Beverage Report. The Enforcement Letter contained completed written survey results, including the penalties and correction order time frames. In the chain of the MHD Survey Results email was a response from LALD-A dated May 28, 2024, 2:09 p.m., "Hello [MHD staff], thank you, [licensee], [licensee staff]." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required 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;	{0 470}			

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{0 470}	Continued From page 5 (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: No further action required.	{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: (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: No further action required.	{0 480}			
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the	{0 630}			

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{0 630}	Continued From page 6 abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: No further action required.	{0 630}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}			

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{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: No further action required.	{0 780}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	{0 790}			

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{0 790}	Continued From page 8 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: No further action required.	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of	{0 810}			

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{0 810}	Continued From page 9 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be	{0 820}			

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{0 820}	Continued From page 10 permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 10, 2024, at 10:35 a.m., during a facility tour, the surveyor observed the following: Occupied Sleeping Rooms: Bedroom #2 occupied by R2: one window measuring 28.5 inches clear width, 17 inches clear height, and 484.5 square inches total open area.	{0 820}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER PUSH SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4757 LOUISIANA AVENUE NORTH CRYSTAL, MN 55428		
(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
{0 820}	Continued From page 11 Bedroom #3 occupied by R3: Three (3) windows. Window one and two measuring 24.5 inches clear width, 17 inches clear height, and 416.5 square inches total open area each window. Window three measuring 28.5 inches clear width, 17 inches clear height, and 484.5 square inches total open area. Unoccupied Sleeping Rooms: Bedroom #1: one window measuring 36 inches clear width, 17 inches clear height, and 612 square inches total open area. The window in bedrooms #1, #2, and #3 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. On July 10, 2024, at 11:36 a.m., via cellular phone call licensed assisted living director (LALD)-A stated they do not have a signed contract with a contractor to replace the windows. LALD-A stated they had contacted four to five contractors, and the contractors were able to install the windows around October or November. LALD-A stated they was trying to find a contractor that would complete the work sooner and would continue to complete the safety fire logs until the windows were replaced. On July 10, 2024, at 12:11 p.m., house manager (HM)-B stated they had received a verbal estimate from a contractor and [licensee] did not sign a contract. HM-B stated the contractor was	{0 820}			

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{0 820}	Continued From page 12 expected to install the new windows in July but canceled with [licensee] prior to that date. On July 10, 2024, at 2:10 p.m., LALD-A provided cell phone screen shots of cellular text message dated April 30, 2024, that indicated a message "Francis Maintenance [sic] Guy, The 3 windows will be \$5500 materials and labor." No Further information was provided.	{0 820}			
{01290} SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: No further action required.	{01290}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days	{01620}			

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{01620}	Continued From page 13 after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}			
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:	{01730}			

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{01730}	Continued From page 14 (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: No further action required.	{01730}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	{01880}			

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{01880}	Continued From page 15 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, and interview, and record review the licensee failed to store prescription medication securely to permit only authorized personnel to have access for all residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 R2's diagnoses include hypertension, depression, osteoporosis, neurogenic bladder (bladder function is disrupted due to nerve damage), diabetes type 2, osteoarthritis (degeneration in the joints), cerebral palsy with spastic quadriparesis (damage to the motor cortex of the brain, weakness in four limbs), and contracted joints right. R2's signed Service Plan dated May 15, 2023, indicated R2 received services including medication setup. R2's medication administration record (MAR)	{01880}			

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{01880}	Continued From page 16 dated July 1, 2024, through July 11, 2024, indicated R2 received the following medications: -Vitamin B-12 tablet 1000 micrograms (mcg) 1 tablet once daily supplement; -Vitamin D3 25 mcg 1 tablet once daily supplement; -metformin 1000 milligrams (mg) 2 tablet extended release once daily anti diabetic; -venlafaxine 150 mg extended release (ER) 1 capsule once daily mood stabilizer; -pantoprazole 40 mg mood stabilizer 1 tablet once daily mood stabilizer; -cefdinir capsules 300 mg tablet twice daily antibiotic; -lorazepam 0.5 mg 1 tablet twice daily mood stabilizer; -Ferrous Sulfate 325 mg 1 tablet daily iron supplement -; -rosuvastatin 40 mg medication 1 tablet daily at bedtime cholesterol; -lamotrigine 150 mg 1 tablet daily at bedtime anti-seizure; -Dayvigo 5 mg 1 tablet daily at bedtime sleep medication; -Melatonin 10 mg one tablet at bedtime sleep medication; -Vaseline - apply to skin tag as needed, acetaminophen 500 mg tablet take one tablet as needed for pain every four hours; -Bacitracin 500 units (u) gm (gram) ointment apply topically to affected areas twice daily for skin irritation as needed; -GS Tussin DM 10-100 mg 10 take 20 milliliters (ml) every 6 hours as needed for cough; -Reguloid Orange 369 gm mix 1 teaspoonful in liquid then take by mouth as needed for constipation; -Senexon-S 8.6-50 mg take 1 tablet as needed at bedtime for constipation; and -baclofen 10 mg 1 tablet 6 times each day as	{01880}			

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{01880}	Continued From page 17 needed muscle relaxer. R3 R3's diagnoses include major depression, post-traumatic stress disorder, spinal cord injury, cocaine use, and paraplegia (paralysis on the lower body). R3's signed Service Plan dated July 7, 2023, indicated R3 received services including medication administration. R3's MAR dated July 1, 2024, through July 11, 2024, indicated R3 received the following medications: -cetirizine 100 mg 1 tablet once daily allergy medication; -Fluticasone Nasal 50 mcg/Spray allergy medication; -Vitamin D3 25 mcg 1 tablet once daily supplement; -Povidone Iodine- Solution 10 percent (%) skin cleaner; -solifenacin 10 mg 1 tablet once daily overactive bladder; -Oyster Shell 500 mg 1 tablet daily calcium supplement; -chlorhexidine 0.12 % swish and spit 15 ml by mouth twice daily mouth cleanser; -quetiapine 50 mg 1 tablet once daily at bedtime bipolar disorder (mood disorder); -amitriptyline 25 mg 1 tablet once daily at bedtime sleep medication; -naproxen 500 mg 1 tablet twice daily as needed for moderate pain; -epinephrine injection 0.3 mg for allergic reaction; -Narcan spray 4 mg 1 spray as a single dose reversal agent for overdose of narcotics; -quetiapine 50 mg tablet repeat one dose in 1 hour if not asleep;	{01880}			

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{01880}	Continued From page 18 -Gavilax powder 17 gm in liquid a drink by mouth for constipation; -Sennexon-S 8.6-50 mg tablet stool softener; -baclofen 10 mg 1 tablet three times daily by mouth muscle relaxer; -gabapentin 300 mg 1 capsule 3 times daily nerve pain; -gabapentin 600 mg 1 tablet 3 times daily tablet nerve pain; -tizanidine 40 mg 1 tablet 3 times daily, muscle relaxer; and -doxycycline 100 mg 1 tablet twice daily antibiotic. R4 R4's diagnoses included depressive disorder. R4's signed Service Plan dated March 1, 2023, indicated R4 received services including medication administration. R4's MAR dated July 1, 2024, through July 11, indicated R4 received the following medications: -Gavilax powder 17 gm into liquid once daily for constipation; -Juluca 50-25 mg 1 tablet once daily anti viral; -Vitamin B-1 100 mg 1 tablet once daily supplement; -ingrezza 40 mg 1 capsule once daily for tardive dyskinesia (uncontrolled body movements); -venlafaxine 150 mg extended release (ER) 2 capsules once daily mood stablelizer; -Vitamin B-12 1,000 mcg tablet once daily, levothyroxine 200 mcg 1 tablet once daily supplement; -Lubricating Plus 0.5% eye drops in both eyes 4 times daily for dry eyes; -Dentagel 1.1% fluoride gel apply a thin strip to brush and brush on teeth twice daily for strong teeth; -docusate sodium 100 mg 1 capsule twice daily	{01880}			

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{01880}	Continued From page 19 stool softener; -levetiracetam 750 mg tablet twice daily anti seizure; -clonazepam tablet 2 mg 1 tablet twice daily (controlled medication) mood stabilizer; -tamsulosin 0.5 mg 1 capsule once daily prostate medication; -Melatonin 3 mg tablet at bedtime for sleep; -rosuvastatin 10 mg 1 tablet once daily for cholesterol; -quetiapine 50 mg 1 tablet twice daily mood stabilizer; -trazadone 100 mg tablet at bedtime for sleep; -beconase 42 mcg/spray suspension 1-2 sprays twice daily as needed allergy medication; -acetaminophen 325 mg 2 tablets every 6 hours as needed for pain, -diclofenac gel 1 percent (%) for pain; -Senna-Time 8.6 mg 1 tablet by mouth twice daily stool softener; -Vaseline as needed for skin irritation; and -Nature Multi Vitamin and Minerals one tablet daily supplement. On July 10, 2024, at 9:40 a.m., in the upper part of the split-level home consisted of an open plan kitchen and dining area. Each resident had an individual two drawer filing cabinet that was located in the dining area. Each individual filing cabinet contained medications for the residents. On the countertop in the kitchen, the surveyor observed a set of keys attached to a green lanyard. The keys were not secured by staff members. On July 10, 2024, at 9:47 a.m., with the keys on the kitchen countertop, the surveyor observed unlicensed personnel (ULP)-G in R2's room. No staff members were located near the set of keys.	{01880}			

Minnesota Department of Health

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{01880}	Continued From page 20 On July 10, 2024, at 10:10 a.m., the surveyor inquired to ULP-G about the set of keys. ULP-G stated the keys were used to open medication cabinets for residents. ULP-G stated the keys should always be secured by staff members, and they did not secure the keys as they did not have pockets. On July 10, 2024, at 10:15 a.m., the survey observed ULP-G pick up the set of keys from the kitchen countertop. On July 10, 2024, at 11:16 a.m., clinical nurse supervisor (CNS)-C stated the keys should be kept with staff at all times and was unsure why ULP-G did not secure the keys. On July 10, 2024, at 11:40 a.m., licensed assisted living director (LALD)-A stated keys should be kept on staff at all times and was unsure why ULP-G left the keys on the kitchen countertop. The licensee's 7.11 Medication Storage policy dated June 2021, indicated only staff will have access to stored medications. No further information was provided.	{01880}			
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced	{01890}			

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{01890}	Continued From page 21 by: No further action required.	{01890}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 28, 2024

Licensee

PUSH Services Inc.

4757 Louisiana Avenue North

Crystal, MN 55428

RE: Project Number(s) SL37222015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 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 . . ."

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 may be 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.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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 survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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>

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

May 28, 2024

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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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: SL3722215-0 On April 22, 2024, through April 26, 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 were three residents: three receiving services under the Assisted Living Facility license. An immediate correction order was identified on April 23 2024, issued for SL3722215-0, tag identification 2310. On April 25, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	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.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's three residents, staff, and visitors. 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: Licensed assisted living director (LALD)-A obtained an assisted living director license on July 14, 2022. On April 22, 2024, at 1:44 p.m., the surveyor observed the Board of Executives for Long-Term Services and Supports (BELTSS) website which indicated licensed assisted living director (LALD)-A held a current assisted living director license, however, LALD-A was not listed as the director of record for the licensee. On April 22, 2024, at 10:22 a.m., during the	0 110			

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0 110	Continued From page 2 entrance conference, LALD-A identified themselves as the LALD for the licensee. On April 22, 2024, at 1:01 p.m., LALD-A stated they did not have a specific person for the Director of Record, and believed holding the LALD was the same as the Director of Record. No other information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required 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;	0 470			

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0 470	Continued From page 3 (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 interview and record review, the licensee failed to develop and implement a staffing plan for determining its staffing level that included an evaluation completed by a registered nurse (RN) at least twice a year (as indicated in Minnesota Administrative Rule 4659.0180). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 22, 2024, at 12:44 p.m., clinical nurse supervisor (CNS)-C stated the licensed assisted living director (LALD) was responsible for creating the staffing plan, and they had not created a staffing plan for the assisted living facility (ALF). On April 22, 2024, at 1:00 p.m., LALD-A stated the posted staff schedule was sufficient for the staffing plan. The licensee failed to provide a staffing plan that was reviewed twice yearly by the RN.	0 470			

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0 470	Continued From page 4 The licensee's 4.06 Staffing and Schedule policy dated August 1, 2021, indicated the CNS would create a written staffing plan that would provide adequate number of qualified direct-care staff to meet residents needs 24-hours a day, 7 days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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: (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 according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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).	0 480			

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0 480	Continued From page 5 The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated April 22, 2024. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 630			

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0 630	Continued From page 6 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses include hypertension, depression, osteoporosis, neurogenic bladder (bladder function is disrupted due to nerve damage), diabetes type 2, osteoarthritis (degeneration in the joints), cerebral palsy with spastic quadriparesis (damage to the motor cortex of the brain, weakness in four limbs), and contracted joints right. R2's signed Service Plan dated May 15, 2023, indicated R2 received services including medication setup, bathing assistance, hygiene grooming assistance, continence care, assistance with positioning, dressing assistance, assistance with transferring, therapeutic exercises, personal laundry, housekeeping and linen change, shopping, food preparation, transporting to medication appointments, money management, behavior management, and socialization. R2's record included a Vulnerability Assessment Abuse Prevention plan dated 2023-2024 and indicated R2 was at risk to be abused by others, however, did not include the following required content: - the person's risk of abusing other vulnerable adults. R3 R3's diagnoses include major depression,	0 630			

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0 630	Continued From page 7 post-traumatic stress disorder, spinal cord injury, cocaine use, and paraplegia (paralysis on the lower body). R3's signed Service Plan dated July 7, 2023, indicated R3 received services including medication administration, house making, shopping, socialization, meals, money management, assistance with making appointments, arranging non-medication transportation, catheter care treatments, continence care, bathing assistance, hygiene and grooming assistance, assistance with positioning and transferring, transporting to medical appointments, behavior management, and wound care. R3's record included a Vulnerability Assessment Abuse Prevention plan dated 2023-2024 indicated R3 was at risk to be abused by others, however, did not include the following required content: - the person's risk of abusing other vulnerable adults. R4 R4's diagnoses included depressive disorder. R4's signed Service Plan dated March 1, 2023, indicated R4 received the following services including medication administration, home making, shopping, socialization, money management, continence care, assistance with making appointments, therapeutic exercises, bathing assistance, hygiene and grooming assistance, dressing assistance, assistance with transferring, assistance with eating, transportation to medical appointments, and behavior management.	0 630			

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0 630	Continued From page 8 R4's record included a Vulnerability Assessment Abuse Prevention plan dated 2023-2024 indicated R4 was at risk to be abused by others, however, did not include the following required content: - the person's risk of abusing other vulnerable adults. On April 24, 2024, at 7:19 a.m., clinical nurse supervisor (CNS)-C stated the registered nurse (RN) was responsible for completing the individualized abuse prevention plan (IAPP) and was included in the assessment of the resident. CNS-C stated they were unaware of the required content for the IAPP, and the licensee did not have the correct assessment form to accurately complete the IAPP. On April 24, 2024, at 7:54 a.m., licensed assisted living director (LALD)-A stated they completed the IAPP for the residents and it contained the required information, "it was just the way it was worded". The licensee 6.05 Individual Abuse Prevention Plan dated August 1, 2021, indicated [licensee] would implement an individual abuse prevention plan for each vulnerable adult and would include the risk to abuse others and the risk to be abused, and to include specific interventions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

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0 680	Continued From page 9 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680			

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0 680	Continued From page 10 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's emergency disaster preparedness plan lacked evidence of the following required content: -policies and procedures for addressing medical documentation that preserves resident information; -policies and procedures for volunteers; -roles under a waiver declared by secretary; and -emergency prep testing requirements including unannounced staff drills using the emergency plan (EP). On April 25, 2024, at 1:55 p.m., licensed assisted living director (LALD)-A stated they purchased the policy and procedures from a consulting company was unaware content was missing. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance indicated [licensee] EPP would contain all the required elements of appendix Z and would be reviewed annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780			

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0 780	Continued From page 11 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 780			

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0 780	Continued From page 12 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 22, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the home so the actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by LALD-A accompanying on the tour. During interview on April 23, 2024 at 2:00 p.m., LALD-A stated that they understood the requirement for the smoke alarms and would get them interconnected. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790			

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0 790	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 April 22, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed the portable fire extinguishers throughout the facility lacked records to show the required monthly visual inspections were performed. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. It was observed that the fire extinguishers in the kitchen and in the lower level were located on the floor and not mounted in accordance with Minnesota Fire Code. MN Fire Code, chapter 7511 indicates fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. During interview on April 23, 2024, at 2:00 p.m., survey staff explained to LALD-A the portable fire extinguishers must be provided monthly visual	0 790			

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0 790	Continued From page 14 inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-A verified the findings and stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 800			

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0 800	Continued From page 15 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 April 22, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed that the door to and wall adjacent to bedroom #2 had significant damage. Areas of the drywall had been ripped off the wall and the corner was damaged enough to expose the wall cavity. It was observed that an exterior-mounted snow shield was installed over the window well of basement bedroom #4 so that it was obstructing the egress window from opening completely to allow for egress. Obstructions in a path of egress would cause a delay in the proper exiting of the space during a fire or similar emergency. All parts of a path of egress must be maintained in proper working condition. Exit paths must be maintained and clear of obstructions. It was observed that the landing at the top of the ramp adjacent to the front door was being used by residents as a smoking area. Although a non-combustible ashtray was present, the wood mulch-filled planter adjacent to the window was filled with discarded cigarette butts. Survey staff explained to the licensee that the discarded cigarette butts were a potential fire hazard if residents' cigarettes were not completely extinguished before discarding them. During interview on April 23, 2024, at 2:00 p.m., LALD-A stated they understood the above-listed	0 800			

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0 800	Continued From page 16 deficiencies.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation	0 810			

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0 810	Continued From page 17 drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 April 24, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Safety", dated August 1, 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility.	0 810			

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0 810	Continued From page 18 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During interview on April 25, 2024, at 10:00 a.m., LALD-A stated she understood the areas of her policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the	0 820			

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0 820	Continued From page 19 commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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 April 22, 2024, at 10:30 a.m. survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, survey staff asked LALD-A to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: Occupied Sleeping Rooms: Bedroom #2 occupied by R2: one window measuring 28.5 inches clear width, 17 inches clear height, and 484.5 square inches total open area. Bedroom #3 occupied by R3: Three (3) windows. Window one and two measuring 24.5 inches	0 820			

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0 820	Continued From page 20 clear width, 17 inches clear height, and 416.5 square inches total open area each window. Window three measuring 28.5 inches clear width, 17 inches clear height, and 484.5 square inches total open area. Unoccupied Sleeping Rooms: Bedroom #1: one window measuring 36 inches clear width, 17 inches clear height, and 612 square inches total open area. The window in bedrooms #1, #2, and #3 did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. On April 22, 2024, survey staff explained to LALD-A that an immediate correction order was issued for the above finding. LALD-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820			

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01290	Continued From page 21	01290			
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of one employee, unlicensed personnel (ULP)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when 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 April 23, 2024, at 12:13 p.m., the surveyor received the licensee's Minnesota Department of	01290			

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01290	Continued From page 22 Human Services NETStudy 2.0 roster for Health Facility Identification (HFID) 37222 and observed ULP-D was affiliated with HFID 33182 Push Services Incorporated. ULP-D was hired on June 15, 2021, to provide direct care services to residents. On April 23, 2024, at 6:57 a.m., the surveyor observed ULP-D administer medications to R2. ULP-D's employee record contained a background study clearance dated June 17, 2021, affiliated to licensee's head office, HFID 33182. On April 24, 2024, at 10:18 a.m., licensed assisted living director stated background checks are required for all employees and should be affiliated with the assisted living facility HFID 37222, and it was an "oversight". The licensee's undated 2.34 Background Checks indicated all employee that provide direct care services to residents require a background check for the current assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	01620			

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01620	Continued From page 23 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 90 calendar days from the previous assessment for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). R2	01620			

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01620	Continued From page 24 R2 admitted to the licensee on May 5, 2023, and began receiving assisted living services. R2's diagnoses include hypertension, depression, osteoporosis, neurogenic bladder (bladder function is disrupted due to nerve damage), diabetes type 2, osteoarthritis (degeneration in the joints), cerebral palsy with spastic quadriparesis (damage to the motor cortex of the brain, weakness in four limbs), and contracted joints right. R2's signed Service Plan dated May 15, 2023, indicated R2 received services including medication setup, bathing assistance, hygiene grooming assistance, continence care, assistance with positioning, dressing assistance, assistance with transferring, therapeutic exercises, personal laundry, housekeeping and linen change, shopping, food preparation, transporting to medication appointments, money management, behavior management, and socialization. R2's medical record included Nurse Assessment dated August 30, 2023. The next 90-day assessment was completed three days late on November 30, 2023. The next 90-day assessment after November 30, 2023, should have been completed by February 28, 2024, but was completed on February 29, 2024. R3 R3 admitted to the licensee on June 25, 2023, and began receiving assisted living services. R3's diagnoses include major depression, post-traumatic stress disorder, spinal cord injury, cocaine use, and paraplegia (paralysis on the lower body).	01620			

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01620	Continued From page 25 R3's signed Service Plan dated July 7, 2023, indicated R3 received services including medication administration, house making, shopping, socialization, meals, money management, assistance with making appointments, arranging non-medication transportation, catheter care treatments, continence care, bathing assistance, hygiene and grooming assistance, assistance with positioning and transferring, transporting to medical appointments, behavior management, and wound care. R3's medical record included Nurse Assessment dated March 6, 2023. The next 90-day assessment was completed on January 3, 2024, 214 days late. The next 90-day assessment after January 3, 2024, should have been completed on April 2, 2024, but was completed on April 3, 2024. R4 R4 admitted to the licensee on June 1, 2023, and began receiving assisted living services. R4's diagnoses included depressive disorder. R4's signed Service Plan dated March 1, 2023, indicated R4 received services including medication administration, home making, shopping, socialization, money management, continence care, assistance with making appointments, therapeutic exercises, bathing assistance, hygiene and grooming assistance, dressing assistance, assistance with transferring, assistance with eating, transportation to medical appointments, and behavior management. R4's medical record included Nurse Assessment dated August 29, 2023. The next 90-day	01620			

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01620	Continued From page 26 assessment was completed on November 29, 2023, three days late. The next 90-day assessment after November 29, 2023, should have been completed by February 27, 2024, but was completed on February 29, 2024. On April 24, 2024, at 7:32 a.m., clinical nurse supervisor (CNS)-C stated the registered nurse (RN) was responsible for the assessments and should be completed every 90-days. CNS-C stated they counted one month as 30 days and did not count the actual number of days. The surveyor inquired about the assessment gap date for R3, CNS-C stated they were not an employee at that time. The licensee's employee roster indicated CNS-C was hired on June 26, 2023. On April 24, 2024, at 7:59 a.m., licensed living assisted director stated the RN was responsible for the resident assessments and if the months are counted, the assessments are not late. The licensee's 6.01 Assessment, Reviews & Monitoring dated August 1, 2024, indicated resident assessments cannot exceed 90 calendar days from the date of the last review. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	01730			

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01730	Continued From page 27 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01730			

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01730	Continued From page 28 review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for three of three residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 admitted to the licensee on May 5, 2023, and began receiving assisted living services. R2's diagnoses include hypertension, depression, osteoporosis, neurogenic bladder (bladder function is disrupted due to nerve damage), diabetes type 2, osteoarthritis (degeneration in the joints), cerebral palsy with spastic quadriparesis (damage to the motor cortex of the brain, weakness in four limbs), and contracted joints right. R2's signed Service Plan dated May 15, 2023, indicated R2 received services including medication setup. R2's medication administration record (MAR) dated April 1, 2024, through April 23, 2024, indicated R2 received the following medications: Nexium 40 milligram (mg) capsule once daily, Vitamin B-12 tablet 1000 micrograms (mcg) 1	01730			

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01730	Continued From page 29 tablet once daily, Vitamin D3 25 mcg 1 tablet once daily, metformin 400 mg 1 tablet extended release once daily, cefdinir capsules 300 mg tablet twice daily, lorazepam 0.5 mg tablet twice daily, ferrous sulfate 325 mg 1 tablet daily, rosuvastatin 40 mg 1 tablet daily at bedtime, lamotrigine 150 mg tablet daily at bedtime, Melatonin 10 mg one tablet at bedtime, Vaseline - apply to skin tag as needed, acetaminophen 500 mg tablet take one tablet as needed every four hours, Bacitracin 500 units (u) gm (gram) ointment apply topically to affected areas twice daily as needed, GS Tussin DM 10-100mg 10 take 20 milliliters (ml) every 6 hours as needed for cough, Reguloid Orange 369g mix 1 teaspoonful in liquid then take by mouth as needed for constipation, and Senexon-S 8.6-50 mg take 1 tablet as needed at bedtime for constipation. On April 23, 2024, at 6:57 a.m., the surveyor observed ULP-D administer medications to R2. R2's resident chart, comprised of multiple documents, lacked the following information:: -statement describing the medication management services that will be provided; -a description of storage of medications based on the residents needs and preferences, risks of diversion, and consistent with the manufactures directions; -documentation of specific resident instructions relating to the administration of medications; -identification of person responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis, and -procedures for staff notifying a registered nurse (RN) when a problem arises with a medication management service.	01730			

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01730	Continued From page 30 R3 R3 admitted to the licensee on June 25, 2023, and began receiving assisted living services. R3's diagnoses include major depression, post-traumatic stress disorder, spinal cord injury, cocaine use, and paraplegia (paralysis on the lower body). R3's signed Service Plan dated July 7, 2023, indicated R3 received services including medication administration. R3's medication administration record (MAR) dated April 1, 2024, through April 23, 2024, indicated R3 received the following medications: Cetirizine 100 mg 1 tablet once daily, Fluticasone Nasal 50 mcg/Spray, Vitamin D3 25 mcg 1 tablet, Povidone Iodine- Solution 10 percent (%), Solifenacin 10 mg 1 tablet once daily, Oyster Shell 500 mg 1 tablet daily, Chlorhexidine 0.12 % swish and spit 15 ml by mouth twice daily, Quetiapine 50 mg 1 tablet once daily at bedtime, amitriptyline 25 mg 1 tablet once daily at bedtime, baclofen 10 mg 1tablet three times daily by mouth, gabapentin 300 mg 1 capsule 3 times daily, gabapentin 600 mg 1tablet 3 times daily tablet, tizanidine 40 mg 1 tablet 3 times daily, naproxen 500 mg 1tablet twice daily as needed for moderate pain, epinephrine injection 0.3 mg for allergic reaction, Narcan spray 4 mg 1spray as a single dose, Quetiapine 50 mg tablet repeat one dose in 1 hour if not asleep, Gavilax powder 17 gm in liquid an drink by mouth and, Sennexon-S 8.6-50 mg tablet. On April 23, 2024, at 9:17 a.m., the surveyor observed ULP-D administer medication to R3.	01730			

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01730	Continued From page 31 R3's resident chart, comprised of multiple documents, lacked the following information: -statement describing the medication management services that will be provided; -a description of storage of medications based on the residents needs and preferences, risks of diversion, and consistent with the manufactures directions; -documentation of specific resident instructions relating to the administration of medications; -identification of person responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis, and -procedures for staff notifying a registered nurse (RN) when a problem arises with a medication management service. R4 R4 admitted to the licensee on June 01, 2023, and began receiving assisted living services. R4's diagnoses included depressive disorder. R4's signed Service Plan dated March 1, 2023, indicated R4 received services including medication administration. R4's medication administration record (MAR) dated April 1, 2024, through April 23, 2024, indicated R4 received the following medications: Dentagel 1.1% fluoride gel apply a thin strip to brush and brush on teeth twice daily, docusate sodium 100 mg 1 capsule twice daily, clonazepam tablet 2 mg 1 tablet twice daily, Quetiapine 50 mg 1 tablet twice daily, Levetiracetam 750 mg tablet twice daily, Tamsulosin 0.5 mg capsules once daily, Melatonin 3 mg tablet at bedtime, Trazadone 100 mg tablet at bedtime, Gavilax powder 17gm into	01730			

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01730	Continued From page 32 liquid once daily, Juluca 50-25 mg tablet once daily, levothyroxine 175 mcg tablet once daily, vitamin B-1 100 mg tablet once daily, Vitamin B-12 1,000 mcg tablet once daily, Ingrezza 40 mg capsule once daily, venlafaxine 150 mg extended release (ER) once daily, Lubricating Plus 0.5% eye drops in both eyes 4 times daily, Nature Multi Vitamin and Minerals one tablet daily, rosuvastatin 10 mg tablet once daily, Beconase AQ 42 mcg spray 1-2 sprays into nostril twice daily as needed, acetaminophen 325 mg tablets 2 tablets 4 times daily as needed, and gavilax powder 17 gm in liquid and drink by mouth as needed. R4's resident chart, comprised of multiple documents, lacked the following information: -statement describing the medication management services that will be provided; -a description of storage of medications based on the residents needs and preferences, risks of diversion, and consistent with the manufactures directions; -documentation of specific resident instructions relating to the administration of medications; -identification of person responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis, and -procedures for staff notifying a registered nurse (RN) when a problem arises with a medication management service. On April 23, 2024, at 7:26 a.m., clinical nurse supervisor (CNS)-C stated each resident had prescribed medications from a medical provider and was unaware of the required content for the Individualized Medication Manage Plan. CNS-C stated they had never completed that documentation for the residents.	01730			

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01730	Continued From page 33 On April 24, at 7:54 a.m., licensed assisted living director (LALD)-A stated the registered nurse (RN) was responsible for the Individualized Medication Manage Plan and was not aware of the required content. The licensee's 7.03 Medication Management Individualized Plan dated August 1, 2021, indicated each resident would have a written statement for medication management services that are provided to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
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 store prescription medication securely to permit only authorized personnel to have access for all residents (R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01880			

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01880	Continued From page 34 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 April 22, 2024, at 10:43 a.m., during a facility tour, in the dining area of the two-level home, the surveyor observed resident medications stored in individual two drawer filing cabinets for R2, R3 and R4 which were locked. Licensed assisted living director (LALD)-A removed a set of keys from an unlocked cabinet in the kitchen that was used to open the individual filing cabinets. On April 22, 2024, at 10:43 a.m., LALD-A stated the keys should be secured by staff at all times and were left unsecured in the kitchen by the unlicensed personnel (ULP) as they were helping a resident. R2 R2's signed Service Plan dated May 15, 2023, indicated R2 received services including medication setup. R2's medication administration record (MAR) dated April 1, 2024, through April 23, 2024, indicated R2 received the following medications: Nexium 40 milligram (mg) capsule once daily, Vitamin B-12 tablet 1000 micrograms (mcg) 1 tablet once daily, Vitamin D3 25 mcg 1 tablet once daily, metformin 400 mg 1 tablet extended release once daily, cefdinir capsules 300 mg tablet twice daily, lorazepam 0.5 mg tablet twice daily, ferrous sulfate 325 mg 1 tablet daily, rosuvastatin 40 mg 1 tablet daily at bedtime, lamotrigine 150 mg tablet daily at bedtime, Melatonin 10 mg one tablet at bedtime, Vaseline -	01880			

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01880	Continued From page 35 apply to skin tag as needed, acetaminophen 500 mg tablet take one tablet as needed every four hours, Bacitracin 500 units (u) gm (gram) ointment apply topically to affected areas twice daily as needed, GS Tussin DM 10-100mg 10 take 20 milliliters (ml) every 6 hours as needed for cough, Reguloid Orange 369g mix 1 teaspoonful in liquid then take by mouth as needed for constipation, and Senexon-S 8.6-50 mg take 1 tablet as needed at bedtime for constipation. On April 22, 2024, at 11:02 a.m., in R2's medication cabinet, the surveyor observed R2's medication bottles and a plastic pill box labeled with the day on each compartment. LALD-A stated medications were setup by the registered nurse on a bi-weekly basis. On April 23, 2024, at 6:57 a.m., the surveyor observed ULP-D administer medications to R2. R3 R3 admitted to the licensee on June 25, 2023, and began receiving assisted living services. R3's diagnoses include major depression, post-traumatic stress disorder, spinal cord injury, cocaine use, and paraplegia (paralysis on the lower body). R3's signed Service Plan dated July 7, 2023, indicated R3 received services including medication administration. R3's medication administration record (MAR) dated April 1, 2024, through April 23, 2024, indicated R3 received the following medications: Cetirizine 100 mg 1 tablet once daily, Fluticasone Nasal 50 mcg/Spray, Vitamin D3 25 mcg 1 tablet,	01880			

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01880	Continued From page 36 Povidone Iodine- Solution 10 percent (%), Solifenacin 10 mg 1 tablet once daily, Oyster Shell 500 mg 1 tablet daily, Chlorhexidine 0.12 % swish and spit 15 ml by mouth twice daily, Quetiapine 50 mg 1 tablet once daily at bedtime, amitriptyline 25 mg 1 tablet once daily at bedtime, baclofen 10 mg 1tablet three times daily by mouth, gabapentin 300 mg 1 capsule 3 times daily, gabapentin 600 mg 1tablet 3 times daily tablet, tizanidine 40 mg 1 tablet 3 times daily, naproxen 500 mg 1tablet twice daily as needed for moderate pain, epinephrine injection 0.3 mg for allergic reaction, Narcan spray 4 mg 1spray as a single dose, Quetiapine 50 mg tablet repeat one dose in 1 hour if not asleep, Gavilax powder 17 gm in liquid an drink by mouth and, Sennexon-S 8.6-50 mg tablet. On April 23, 2024, at 9:17 a.m., the surveyor observed ULP-D administer medication to R3. R4 R4's signed Service Plan dated March 1, 2023, indicated R4 received services including medication administration. R4's medication administration record (MAR) dated April 1, 2024, through April 23, 2024, indicated R4 received the following medications: Dentagel 1.1% fluoride gel apply a thin strip to brush and brush on teeth twice daily, docusate sodium 100 mg 1 capsule twice daily, clonazepam tablet 2 mg 1 tablet twice daily (controlled medication), Quetiapine 50 mg 1 tablet twice daily, Levetiracetam 750 mg tablet twice daily, Tamsulosin 0.5 mg capsules once daily, Melatonin 3 mg tablet at bedtime, Trazadone 100 mg tablet at bedtime, Gavilax powder 17gm into liquid once daily, Juluca 50-25 mg tablet once daily, levothyroxine 175 mcg	01880			

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01880	Continued From page 37 tablet once daily, vitamin B-1 100 mg tablet once daily, Vitamin B-12 1,000 mcg tablet once daily, Ingrezza 40 mg capsule once daily, venlafaxine 150 mg extended release (ER) once daily, Lubricating Plus 0.5% eye drops in both eyes 4 times daily, Nature Multi Vitamin and Minerals one tablet daily, rosuvastatin 10 mg tablet once daily, Beconase AQ 42 mcg spray 1-2 sprays into nostril twice daily as needed, acetaminophen 325 mg tablets 2 tablets 4 times daily as needed, and gavalax powder 17 gm in liquid and drink by mouth as needed. On April 22, 2024, at 11:02 a.m., in R4's medication cabinet, the surveyor observed R4's medication bottles and a plastic pill box labelled with the day on each compartment. There was a lockbox within the cabinet which contained clonazepam tablet 2 mg medication bottle. LALD-A stated medications were setup by the registered nurse on a bi-weekly basis. The licensee's undated 7.11 Medication & Treatment policy indicated medications managed by the licensee should be stored to prevent diversion and controlled substances will be stored under a double lock system. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890			

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01890	Continued From page 38 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to discard expired medication for two of four residents (R2, R4). In addition, the licensee failed to ensure medications were maintained with the original prescription drug label for one of three residents (R3). 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). R2 R2's signed Service Plan dated May 15, 2023, indicated R2 received services including medication setup. On April 22, 2024, at 10:43 a.m., the surveyor observed R2's locked medication cabinet which contained baclofen 10 milligram (mg) card expired November 2023 and prednisone 20 mg card expired January 2024. R4 R4's signed Service Plan dated March 1, 2023, indicated R4 received services including medication administration. On April 22, 2024, at 10:44 a.m., the surveyor	01890			

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01890	Continued From page 39 observed R4's locked medication cabinet which contained Dimetapp Cold and Cough bottle expired October 2023, Narcan Nasal Spray expired November 2023, Mature Multi expired May 2021 and Chlorhexidine Gluconate Oral Rinse 0.12 percent (%) expired February 2024. R3 R3's signed Service Plan dated March 1, 2023, indicated R3 received services including medication administration. On April 22, 2024, at 11:05 a.m., in the medication cabinet for R3, the surveyor observed an orange pill container that contained seven blue and white striped capsules with the marking "DLX 60 AP". There was no identifying resident information on the pill container, medication name, medication dose, expiry date, ordering prescriber, or directions for medication administration. On April 22, 2024, at 10:47 a.m., licensed assisted living director (LALD)-A stated the registered nurse (RN) checked for expired medications every month and was responsible for removing expired medications, "I don't know why they did not catch these." On April 22, 2024, at 11:05 a.m., LALD-A stated medication pill containers should have identifying information on the container and they were unsure why the medication pill container did not have the correct label. On April 22, 2024, at 12:33 p.m., clinical nurse supervisor (CNS)-C stated they checked for expired medications during medication setup for residents. CNS-C stated the expired medications should have been returned to the pharmacy and	01890			

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01890	Continued From page 40 there was no safe place to keep them. CNS-C stated the LALD should have returned the medications to the pharmacy, "a long time ago." On April 22, 2024, at 12:47 p.m., CNS-C stated all medication pill bottles should have the resident name, the medication name, the dose, the frequency, and the route of administration. CNS-C stated the last time they setup medications for residents, all the medication pill containers were labeled. On April 22, 2024, at 12:52 p.m., the surveyor observed the LALD-A on a cellular phone to an unknown person, "expired meds need to be taken away". The licensee's 7.13 Medication & Treatment policy dated August 1, 2021, indicated all medications dispensed from the pharmacy must bear the original prescription label. The licensee's 7.23 Medication Disposal policy dated August 1, 2021, indicated expired medications will be disposed of according to accepted practices of the Minnesota board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date	02310			

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NAME OF PROVIDER OR SUPPLIER PUSH SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4757 LOUISIANA AVENUE NORTH CRYSTAL, MN 55428			
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02310	Continued From page 41 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for three of three residents (R2, R3, R4) that had hospital bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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: R2 R2's diagnoses include hypertension, depression, osteoporosis, neurogenic bladder (bladder that does not work), Diabetes type 2, osteoarthritis (degeneration in the joints), cerebral palsy with spastic quadriparesis (damage to the motor cortex of the brain, weakness in four limbs), and contracted joints right. R2's signed Service Plan dated May 15, 2023, indicated R2 received the following services including medication setup, bathing assistance, hygiene grooming assistance, continence care, assistance with positioning, dressing assistance, assistance with transferring, therapeutic exercises, personal laundry, housekeeping and linen change, shopping, food preparation,	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37222	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER PUSH SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4757 LOUISIANA AVENUE NORTH CRYSTAL, MN 55428			
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02310	Continued From page 42 transporting to medication appointments, money management, behavior management, and socialization. R2's record included a Vulnerability Assessment Abuse Prevention plan dated 2023-2024 which indicated R2 had side rails and bed mobility devices and R2 had bilateral bed rails. On April 23, 2024, at 10:37 a.m., during a facility tour, the surveyor observed R2's hospital bed with identical bilateral bed rails. The length of the bedrails were 32 inches ("). There were three sections on each bed rail. Starting from the left side of the rail, there were two areas that measured three- and one-half inches each with a height of 12" The next area had five sections that measured two- and one-half inches each in length with a height of 18". The next area had two sections that measured three- and one-half inches in length with a height of 12". There were no identifying labels on the bed rails. The bed rails were clamped onto the hospital bed with a clamp in the middle of the bed. There was a locking pin missing on the right rail. The bedrail was loose when pushed or pulled. R2's record lacked: -Device Evaluation for hospital bed rails; -Documentation the bed rails were installed, used, and maintained per manufacturer's guidelines; -Documentation of bed rails for areas of entrapment, stability, and correct installation; -Documentation the licensee explained the risk versus benefits of the bed rail usage with the resident and/or the resident's representative; -Documentation of the bed rail zones of entrapment measurements, and; -Assessment of bed rails every 90 days.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37222	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
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02310	Continued From page 43 R3 R3's diagnoses include major depression, post-traumatic stress disorder, spinal cord injury, cocaine use, and paraplegia (paralysis on the lower body). R3's signed Service Plan dated July 7, 2023, indicated R3 received the following services including medication administration, house making, shopping, socialization, meals, money management, assistance with making appointments, arranging non-medication transportation, catheter care treatments, continence care, bathing assistance, hygiene and grooming assistance, assistance with positioning and transferring, transporting to medical appointments, behavior management, and wound care. R3's record included a Vulnerability Assessment Abuse Prevention plan dated 2023-2024 which indicated R3 had side rails and bed mobility devices and R2 has a half rail on the hospital bed. On April 23, 2024, at 10:37 a.m., during a facility tour, the surveyor observed R3's hospital bed with identical bilateral bed rails. The length of the bed rails were 32". There were three sections to the bed rails. Starting from the left side of the rail, there were two areas that measured three- and one-half inches each with a height of 12". The next area had five sections that measured two- and one-half inches each in length with a height of 18". The next area had two sections that measured three- and one-half inches in length with a height of 12". There were no identifying labels on the bed rails. The bed rails were clamped onto the hospital bed with a clamp. The	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37222	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
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02310	Continued From page 44 bedrail was loose when pushed or pulled. R3's record lacked: -Device Evaluation for hospital bed rails; -Documentation the bed rails were installed, used, and maintained per manufacturer's guidelines; -Documentation of bed rails for areas of entrapment, stability, and correct installation; -Documentation the licensee explained the risk versus benefits of the bed rail usage with the resident and/or the resident's representative; -Documentation of the bed rail zones of entrapment measurements, and; -Assessment of bed rails every 90 days. R4 R4's diagnoses included depressive disorder. R4's signed Service Plan dated March 1, 2023, indicated R4 received the following services including medication administration, home making, shopping, socialization, money management, continence care, assistance with making appointments, therapeutic exercises, bathing assistance, hygiene and grooming assistance, dressing assistance, assistance with transferring, assistance with eating, transportation to medical appointments, and behavior management. R4's record included a Vulnerability Assessment Abuse Prevention plan dated 2023-2024 which indicated R4 had side rails and bed mobility devices and R4 has a half rail on the hospital bed. On April 23, 2024, at 10:37 a.m., during a facility tour, the surveyor observed R4's hospital bed with identical bilateral bed rails. The total length of	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37222	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
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02310	Continued From page 45 the bed rails were 53" and the height was 17". There were four sections to the bed rail. Starting from left to right, there was one open area that measured three- and one-half inches. The next area has three sections that measured 37" in length and each section's height was four inches. The next area was six inches in length and the height was 17". The next area had three sections with a length of six inches and the height was three inches per section. There were no identifying labels on the bed rails. The bed rail was firmly attached with two poles underneath the mattress of the bed. The bed rail slots into the poles were secured with a pin at each end of the pole. R4's record lacked: -Device Evaluation for hospital bed rails; -Documentation the bed rails were installed, used, and maintained per manufacturer's guidelines; -Documentation of bed rails for areas of entrapment, stability, and correct installation; -Documentation the licensee explained the risk versus benefits of the bed rail usage with the resident and/or the resident's representative; -Documentation of the bed rail zones of entrapment measurements, and; -Assessment of bed rails every 90 days. On April 24, 2024, at 10:16 a.m., licensed assisted living director (LALD)-A stated the bed rail assessment was included in the individual abuse prevention plan and there was not a separate bed rail assessment for each resident. On April 24, 2024, at 12:21 p.m., clinical nurse supervisor (CNS)-C stated the bed rail assessment is completed when the resident moves in, and the registered nurse is required to	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37222	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
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02310	Continued From page 46 complete the assessment. CNS-C stated the bed rail assessment is completed to determine if a resident can use the bed rail for mobility or transferring. CNS-C stated the previous nurse completed the bed rail assessments and was unsure why the assessments lacked the required content. CNS-C stated they had not completed bed rail assessments for the current residents. On April 24, 2024, at 12:27 p.m., LALD-A stated the registered nurse (RN) is responsible for the bed rail assessment and was unaware of the required assessment content for bed rails. LALD-C stated now they had looked at the required content for bed rail assessment, and the required content, "is a lot" and this was not completed prior to the survey. LALD-C stated they were waiting for the exit conference to make all the necessary corrections. The Food and Drug Administration's (FDA), A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006 indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37222	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/26/2024
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02310	Continued From page 47 intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensees undated Nursing 6.28 Side Rail policy indicated the registered nurse (RN) will conduct an assessment to identify the intended purpose of the siderail and determine if the bedrail is safe and also be consistent with the Food, and Drug Administration (FDA) recommendations.	02310			

Minnesota Department of Health

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02310	Continued From page 48 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On April 25, 2024, the immediacy of correction order 2310 was removed, however non-compliance remained, and the scope and level remained unchanged.	02310			

Type: Full
Date: 04/22/24
Time: 11:00:00
Report: 1031241108

Food and Beverage Establishment Inspection Report

Page 1

Location:

Push Services Inc
4757 Louisiana Avenue North
Crystal, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0037851
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124500323
ID #:

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

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

3-501.17B **** Priority 2 ****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

DELI HAM AND OTHER PROCESSED MEAT NOT DATE MARKED. FOLLOW ABOVE DIRECTION.

Comply By: 04/25/24

4-300 Equipment Numbers and Capacities

4-301.12B **** Priority 2 ****

MN Rule 4626.0680B Provide sink compartments in the 3 compartment sink large enough to accommodate immersion of the largest equipment and utensils.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 04/25/24

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE. PROVIDE IRREVERSIBLE MEASURING DEVICE AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS. MARK MAX TEMP IN LOG. ANY TEMP 160F AND OVER IS A PASS.

Comply By: 04/22/24

Type: Full
Date: 04/22/24
Time: 11:00:00
Report: 1031241108
Push Services Inc

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)
Comply By: 04/25/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
MICROWAVE ABOVE RANGE MISSING PARTS. TOP AREA OF MICROWAVE IS TAPPED. REMOVE TAPE AND CLEAN. REPAIR OR REPLACE MICROWAVE OVEN.
Comply By: 05/13/24

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.
OVEN INTERIOR FOUND WITH ENCRUSTED FOOD DEBRIS THROUGHOUT CAVITY. CLEAN AND MAINTAIN CLEAN.
Comply By: 05/13/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
GROUT ON COUNTER ABOVE DISH MACHINE BROKEN/MISSING. ONE TILE IN SAME AREA LOOSE. REATTACH TILE AND REPAIR GROUT.
Comply By: 05/13/24

Surface and Equipment Sanitizers

Chlorine: = 100 at Degrees Fahrenheit
Location: Spray Sanitizer
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Meatball
Temperature: 36 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Type: Full
Date: 04/22/24
Time: 11:00:00
Report: 1031241108
Push Services Inc

Food and Beverage Establishment Inspection Report

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	4	3

Inspection conducted by Chris F.

All violations discussed with Ralph during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Staff must prepare sanitizer bucket or squirt bottle daily. Check concentration of sanitizer throughout day with test strips (50-200ppm Chlorine). Dump and replace sanitizer solution as needed.
- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.
- Make sure to datemark any prepared cold items that are kept in refrigerator.
- Employee food needs to be labeled and separated from residents food.
- Discontinue use of any pre-made sani wipes or sprays without first checking concentration. Contact inspector if questions about doing this arise.
- Items for printer need to be separated from kitchen items by space. Provide enough space that items do not get mixed.
- Cutting boards should be utilized as food contact surfaces and not counters or plates.Discard cutting boards if they get too marred.
- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.
- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

Type: Full
Date: 04/22/24
Time: 11:00:00
Report: 1031241108
Push Services Inc

Food and Beverage Establishment Inspection Report

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

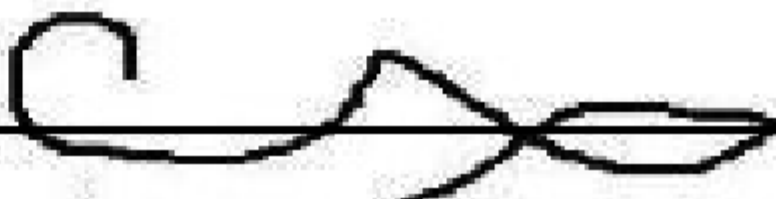
I acknowledge receipt of the Environmental Health inspection report number 1031241108 of 04/22/24.

Certified Food Protection Manager Princess M Yamforh-Nimely

Certification Number: FM109390 Expires: 01/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ralph Tucker
Person in Charge

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

Report #: 1031241108

m

DEPARTMENT OF HEALTH

Environmental Health

Food, Pools, and Lodging

625 Robert St. N

St. Paul

No. of RF/PHI Categories Out

1

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

04/22/24

Time In

11:00:00

Time Out

Push Services Inc

Address

4757 Louisiana Avenue North

City/State

Crystal, MN

Zip Code

55428

Telephone

6124500323

License/Permit #

0037851

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

IN=in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

Compliance Status

COS

R

Supervision

1

IN

OUTPIC knowledgeable; duties & oversight

2

IN

OUT N/ACertified food protection manager, duties

Employee Health

3

IN

OUTMgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUTProper use of reporting, restriction & exclusion

5

IN

OUTProcedures for responding to vomiting & diarrheal events

Good Hygienic Practices

6

IN

OUT

N/O

Proper eating, tasting, drinking, or tobacco use

7

IN

OUT N/ONo discharge from eyes, nose, & mouth

Preventing Contamination by Hands

8

IN

OUT N/ON/AHands clean & properly washed

9

IN

OUT N/A N/ONo bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed

10

IN

OUTAdequate handwashing sinks supplied/accessible

Approved Source

11

IN

OUTFood obtained from approved source

12

IN

OUT N/A

N/O

Food received at proper temperature

13

IN

OUTFood in good condition, safe, & unadulterated

14

IN

OUT

N/A

 N/ON/ARequired records available; shellstock tags, parasite destruction

Protection from Contamination

15

IN

OUT N/A N/ON/AFood separated and protected

16

IN

OUT N/AFood contact surfaces: cleaned & sanitized

17

IN

OUTProper 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/OProper reheating procedures for hot holding

20

IN

OUT

N/A

 N/OProper cooling time & temperature

21

IN

OUT N/A

N/O

Proper hot holding temperatures

22

IN

OUT N/AFood in good condition, safe, & unadulterated

23

IN

OUT

N/A

 N/OProper cold holding temperatures

24

IN

OUT

N/A

 N/ON/AProper date marking & disposition

25

IN

OUT

N/A

 N/ON/AProcedures for responding to vomiting & diarrheal events

Consumer Advisory

26

IN

OUT N/ON/AConsumer advisory provided for raw/undercooked food

Highly Susceptible Populations

27

IN

OUT N/ON/AConsumer advisory provided for raw/undercooked food

Food and Color Additives and Toxic Substances

28

IN

OUT N/ON/AConsumer advisory provided for raw/undercooked food

29

IN

OUT

N/A

 N/ON/AConsumer advisory provided for raw/undercooked food

Conformance with Approved Procedures

30

IN

OUT N/ON/AConsumer advisory provided for raw/undercooked food

Risk factors (RF) are improper practices or proceeedures 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

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

IN

OUT

N/A

Water & ice obtained from an approved source

32

IN

OUT

N/A

 N/ON/AVariance obtained for specialized processing methods

Food Temperature Control

33

IN

OUT N/A N/ON/AProper 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/ON/AApproved thawing methods used

36

IN

OUT N/ON/AThermometers provided & accurate

Food Identification

37

IN

OUT N/A N/ON/AFood properly labled; original container

Prevention of Food Contamination

38

IN

OUT N/A N/ON/AInsects, rodents, & animals not present

39

IN

OUT N/A N/ON/AContamination prevented during food prep, storage & display

40

IN

OUT N/A N/ON/APersonal cleanliness

41

IN

OUT N/A N/ON/AWiping cloths: properly used & stored

42

IN

OUT N/A N/ON/AWashing fruits & vegetables

Proper Use of Utensils

43

IN

OUT N/A N/ON/AIN-use utensils: properly stored

44

IN

OUT N/A N/ON/OUTensils, equipment & linens: properly stored, dried, & handled

45

IN

OUT N/A N/ON/ASingle-use/single service articles: properly stored & used

46

IN

OUT N/A N/ON/AGloves used properly

Utensil Equipment and Vending

47

IN

OUT N/A N/ON/AXFood & non-food contact surfaces cleanable, properly designed, constructed, & used

48

IN

OUT N/A N/ON/AXWarewashing facilities: installed, maintained, & used; test strips

49

IN

OUT N/A N/ON/AXNon-food contact surfaces clean

Physical Facilities

50

IN

OUT N/A N/ON/AXHot & cold water available; adequate pressure

51

IN

OUT N/A N/ON/AXPlumbing installed; proper backflow devices

52

IN

OUT N/A N/ON/AXSewage & waste water properly disposed

53

IN

OUT N/A N/ON/AXToilet facilities: properly constructed, supplied, & cleaned

54

IN

OUT N/A N/ON/AXGarbage & refuse properly disposed; facilities maintained

55

IN

OUT N/A N/ON/AXPhysical facilities installed, maintained, & clean

56

IN

OUT N/A N/ON/AXAdequate ventilation & lighting; designated areas used

57

IN

OUT N/A N/ON/AXCompliance with MCIAA

58

IN

OUT N/A N/ON/AXCompliance with licensing & plan review

Food Recalls:

Person in Charge (Signature)

Date: 04/22/24

Inspector (Signature)

Type: Full
Date: 04/22/24
Time: 11:00:00
Report: 1031241108

Food and Beverage Establishment Inspection Report

Page 1

Location:

Push Services Inc
4757 Louisiana Avenue North
Crystal, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0037851
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124500323
ID #:

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

The following orders were issued during this inspection.

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

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

DELI HAM AND OTHER PROCESSED MEAT NOT DATE MARKED. FOLLOW ABOVE DIRECTION.

Comply By: 04/25/24

4-300 Equipment Numbers and Capacities**4-301.12B ** Priority 2 ****

MN Rule 4626.0680B Provide sink compartments in the 3 compartment sink large enough to accommodate immersion of the largest equipment and utensils.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 04/25/24

4-300 Equipment Numbers and Capacities**4-302.13B ** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE. PROVIDE IRREVERSIBLE MEASURING DEVICE AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS. MARK MAX TEMP IN LOG. ANY TEMP 160F AND OVER IS A PASS.

Comply By: 04/22/24

Type: Full
Date: 04/22/24
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Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
ESTABLISHMENT DOES NOT HAVE SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM BLEACH, 150-400PPM QUAT)
Comply By: 04/25/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
MICROWAVE ABOVE RANGE MISSING PARTS. TOP AREA OF MICROWAVE IS TAPPED. REMOVE TAPE AND CLEAN. REPAIR OR REPLACE MICROWAVE OVEN.
Comply By: 05/13/24

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.
OVEN INTERIOR FOUND WITH ENCRUSTED FOOD DEBRIS THROUGHOUT CAVITY. CLEAN AND MAINTAIN CLEAN.
Comply By: 05/13/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
GROUT ON COUNTER ABOVE DISH MACHINE BROKEN/MISSING. ONE TILE IN SAME AREA LOOSE. REATTACH TILE AND REPAIR GROUT.
Comply By: 05/13/24

Surface and Equipment Sanitizers

Chlorine: = 100 at Degrees Fahrenheit
Location: Spray Sanitizer
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Meatball
Temperature: 36 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Type: Full
Date: 04/22/24
Time: 11:00:00
Report: 1031241108
Push Services Inc

Food and Beverage Establishment Inspection Report

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	4	3

Inspection conducted by Chris F.

All violations discussed with Ralph during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Staff must prepare sanitizer bucket or squirt bottle daily. Check concentration of sanitizer throughout day with test strips (50-200ppm Chlorine). Dump and replace sanitizer solution as needed.
- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.
- Make sure to datemark any prepared cold items that are kept in refrigerator.
- Employee food needs to be labeled and separated from residents food.
- Discontinue use of any pre-made sani wipes or sprays without first checking concentration. Contact inspector if questions about doing this arise.
- Items for printer need to be separated from kitchen items by space. Provide enough space that items do not get mixed.
- Cutting boards should be utilized as food contact surfaces and not counters or plates.Discard cutting boards if they get too marred.
- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air dry, as discussed during inspection.
- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

Type: Full
Date: 04/22/24
Time: 11:00:00
Report: 1031241108
Push Services Inc

Food and Beverage Establishment Inspection Report

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

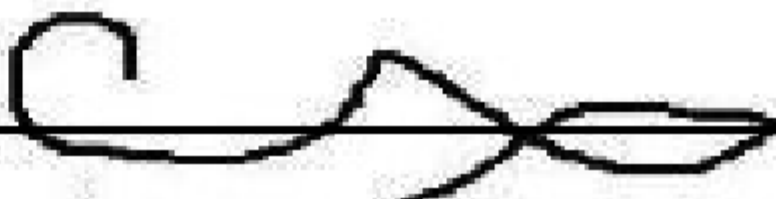
I acknowledge receipt of the Environmental Health inspection report number 1031241108 of 04/22/24.

Certified Food Protection Manager Princess M Yamforh-Nimely

Certification Number: FM109390 Expires: 01/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ralph Tucker
Person in Charge

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

Report #: 1031241108

m

DEPARTMENT OF HEALTH

Environmental Health

Food, Pools, and Lodging

625 Robert St. N

St. Paul

No. of RF/PHI Categories Out

1

No. of Repeat RF/PHI Categories Out

0

Legal Authority MN Rules Chapter 4626

Date

04/22/24

Time In

11:00:00

Time Out

Push Services Inc

Address

4757 Louisiana Avenue North

City/State

Crystal, MN

Zip Code

55428

Telephone

6124500323

License/Permit #

0037851

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item

Mark "X" in appropriate box for COS and/or R

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

Compliance Status

COS

R

Supervision

1

IN

OUT

PIC knowledgeable; duties & oversight

2

IN

OUT

N/A

Certified food protection manager, duties

Employee Health

3

IN

OUT

Mgmt/Staff;knowledge,responsibilities&reporting

4

IN

OUT

Proper use of reporting, restriction & exclusion

5

IN

OUT

Procedures for responding to vomiting & diarrheal events

Good Hygienic 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 proceeedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

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

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

COS

R

Safe Food and Water

30

IN

OUT

N/A

Pasteurized eggs used where required

31

Water & ice obtained from an approved source

32

IN

OUT

N/A

Variance obtained for specialized processing methods

Food Temperature Control

33

Proper cooling methods used; adequate equipment for temperature control

34

IN

OUT

N/A

N/O

Plant food properly cooked for hot holding

35

IN

OUT

N/A

N/O

Approved thawing methods used

36

Thermometers provided & accurate

Food Identification

37

Food properly labled; original container

Prevention of Food Contamination

38

Insects, rodents, & animals not present

39

Contamination prevented during food prep, storage & display

40

Personal cleanliness

41

Wiping cloths: properly used & stored

42

Washing fruits & vegetables

COS

R

Proper Use of Utensils

43

In-use utensils: properly stored

44

Utensils, equipment & linens: properly stored, dried, & handled

45

Single-use/single service articles: properly stored & used

46

Gloves used properly

Utensil Equipment and Vending

47

X

Food & non-food contact surfaces cleanable, properly designed, constructed, & used

48

X

Warewashing facilities: installed, maintained, & used; test strips

49

X

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: 04/22/24

Inspector (Signature)