Electronically Delivered

March 2, 2023

Licensee
Yorkshire Of Edina Senior Lvg
7141 York Avenue South
Edina, MN 55435

RE: Project Number(s) SL32541015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

**St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00**

**The total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

**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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32541 | A. BUILDING: _____ B. WING _____ | 01/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| YORKSHIRE OF EDINA SENIOR LVG | 7141 YORK AVENUE SOUTH EDINA, MN 55435 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL32541015-0<br><br>On January 9, 2023, through January 12, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 91 residents, all of whom received services under the provider's Assisted Living with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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=F | 144G.10 Subdivision 1a Assisted living director license required | 0 110 | | |

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| 0 110 | Continued From page 1<br><br>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.?<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On January 9, 2023, at 1:00 p.m., The Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website was viewed and indicated LALD-A held a LALD license effective through October 31, 2023, however, the website did not indicate LALD-A was listed as Director of Record for the licensee.<br><br>On January 9, 2023, at 1:30 p.m., during an interview with assistant director of health services (ADHS)-B and, LALD-A, ADHS-B and LALD-A stated "we were not aware that they needed to add themselves as Director of Record through BELTSS". | 0 110 | | |

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| 0 110 | Continued From page 2<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 110 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 10, 2023, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 0 480 | | |

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| 0 480 | Continued From page 3<br>(21) days | 0 480 | | |
| 0 650 SS=D | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the employee record contained the required content for one of two employees unlicensed personnel (ULP-E) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or | 0 650 | | |

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| 0 650 | Continued From page 4<br>safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-E employee record lacked documentation of required training.<br><br>ULP-E worked as a contracted agency staff for the licensee, and has worked for the licensee since September 2022 (unknown start date).<br><br>On January 10, 2023, at 8:30 a.m., ULP-E was observed to provide cares and medication administration to licensee clients.<br><br>ULP-E employee record lacked documentation of the following training:<br>-overview of 144G statutes<br>-review of provider's policies and procedures<br>-review of types of Assisted Living services the employee will provide<br>-principles of person-centered planning<br>-orientation to each specific resident<br><br>On January 11, 2023, at 9:20 a.m., assistant director of health services (ADHS)-D provided a binder for training of agency employees and indicated all new agency employees are required to review the binder with a licensed nurse prior to providing care. ADHS-D stated she was unable to provide documentation of the binder review for ULP-E to include the above training.<br><br>The licensee's Employee File Checklist dated | 0 650 | | |

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| 0 650 | Continued From page 5<br>April 2022, included the topics of specialized department training and skills checklist and included orientation and annual training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 650 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 residents). | 0 800 | | |

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| 0 800 | Continued From page 6<br>The findings include:<br><br>On January 12, 2023, from approximately 9:15 a.m. to 11:30 a.m., survey staff toured the facility with the director of maintenance (DOM)-I. During the facility tour, survey staff observed the following:<br><br>1. The fan in the third-floor trash room was not working.<br>2. The ceiling in the Hazelton Hobby room was damaged and looked like there was a water leak recently.<br><br>DOM-I verbally confirmed survey staff observations during the facility tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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. | 0 810 | | |

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| 0 810 | Continued From page 7<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).<br><br>The findings include: | 0 810 | | |

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| 0 810 | Continued From page 8<br><br>During interview on January 12, 2023, at 11:45 a.m., the director of maintenance (DOM)-I stated they were planning to do drills monthly. Drill logs showed evacuation drills completed on 6/9/2022, 7/20/2022, 8/20/2022, 8/30/2022, 11/3/2022, and 12/23/2022. Although six drills had been completed, the frequency did not comply with the requirements.<br><br>Review of the fire policy showed the following:<br><br>1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who need assistance during an evacuation.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services | 01640 | | |

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| 01640 | Continued From page 9<br>and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of five residents (R7) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br>The findings include:<br><br>R7<br>R7 service plan lacked a signature or other authentication by the facility and by the resident.<br><br>R7 had diagnoses to include "limitation of activities due to disability." | 01640 | | |

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| 01640 | Continued From page 10<br><br>R7 was admitted for services on October 28, 2022. R7 services included bathing and medication administration.<br><br>On January 10, 2023, at 8:30 a.m., unlicensed personnel (ULP)-E was observed to assist R7 to walk from the bed to the bathroom, and assisted her onto the toilet. ULP-E then placed a incontinent brief, and assisted R7 with dressing and grooming.<br><br>On January 10, 2023, at 8:40 a.m., ULP-E stated the care plan for R7 lacked documentation of physical assist with dressing. In addition, ULP-E stated R7 cares and service needs increased after most recent hospitalization (unsure of exact date), but were not added to the care plan.<br><br>On January 10, 2023, at 9:00 a.m., ULP-E received a phone call from the assistant director of health services (ADHS)-B. ULP-E stated she was told by ADHS-B that R7 now needed assistance with dressing, but verified dressing was not included on the care plan.<br><br>R7 undated and unsigned service plan, was provided on January 11, 2023 (during the onsite survey) and now included the service of physical assistance with dressing effective January 10, 2023.<br><br>On January 11, 2023, at 9:20 a.m., regional director of operations (RDO)-D verified the service plan lacked the required services and signatures. RDO-D verified the physical assistance with dressing was added to the service plan during the onsite survey.<br><br>The licensee's Service Plan policy dated December 2022, indicated "date/signature of | 01640 | | |

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|---|---|---|---|
| | 32541 | A. BUILDING: _____ B. WING _____ | 01/12/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 01640 | Continued From page 11<br>client or the client's representative each time a modification is made. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone."<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 01640 | | |
| 01760 SS=D | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for three of three residents (R5, R6, R11).<br><br>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 | 01760 | | |

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|---|---|---|---|---|
| 01760 | Continued From page 12 | 01760 | | |

cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R5 and R6 medications were administered outside of the prescribed times listed on the medication administration record (MAR).

R5 had diagnoses to include congestive heart failure (CHF) and gastroesophageal reflux (GERD).

R5 undated service plan indicated services to include medication administration and assistance with application and removal of compression stockings.

On January 10, 2023, at 9:40 a.m., registered nurse (RN)-F was observed to administer Pantoprazole (decreases acid production in the stomach) 40 milligrams/mg and Famotidine (decreases acid production in the stomach) 20 mg to R5 at 9:40 a.m. The medications were ordered to be given at 7:00 a.m., and one hour prior to breakfast. R5 indicated that she had already eaten her breakfast. In addition, R5 received Systane eye drops, 2 drops in each eye. RN-F stated the medications were given late as the scheduled agency unlicensed personnel (ULP) did not report to work, so RN-F assisted with administration of medications for six residents.

Prescriber's orders, dated March 23, 2022, included orders for Famotidine 20 mg, 2x a day, before meals at 7 a.m. and 4 p.m., one hour prior

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| 01760 | Continued From page 13<br>to meals, Pantoprazole 40 mg at 7 a.m. and 4 p.m., and Systane, 2 drops, twice daily at 8:00 a.m., and 8:00 p.m.<br><br>R6<br>R6 had diagnoses to include coronary artery disease, and Sjogren's syndrome (disorder characterized by dry eyes and dry mouth).<br><br>R6 service plan dated March 21, 2022, indicated services to include medication administration.<br><br>On January 10, 2023, at 10:19 a.m., RN-F was observed to administer Systane Gel 0.3%, to R6 right lower eye lid, and Systane eye drops, two drop in each eye. RN-F again verified the medications were to be administered at 8:00 a.m., and were administered late.<br><br>Prescriber's orders, dated March 22, 2022, included orders for Systane 2 milliliters, instill 2 drops into both eyes three times daily at 8:00 a.m., 2:00 p.m., and 8:00 p.m., and Systane Gel 0.3%, three times a day, at 8:00 a.m., 1:00 p.m., and 8:00 p.m.<br><br>R11<br>R11 had diagnoses to include Congestive Heart Failure (CHF) and services to include medication management.<br><br>On January 10, 2023, at 12:40 p.m., R11 stated on January 4, 2023, at 8:00 p.m., an unknown unlicensed personnel (ULP) entered her apartment and handed her a cup of pills. R11 indicated one of the medications in question was Coumadin, and stated she received a dose with her morning medications. R11 looked at the content of the cup, and told the ULP that the medications were not the medications to be given | 01760 | | |

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|---|---|---|---|---|
| 01760 | Continued From page 14<br>at 8:00 p.m. The ULP stated they were her medications and left the apartment. R11 stated she did not take the medications as she was certain they were incorrect. The next morning, R11 notified the nurse manager about the situation, and the nurse manager obtained a blood pressure and pulse reading, and the nurse manager stated she would investigate the medication error. R11 stated she did not recognize the ULP who administered the medications, and stated there are always different people who provide medications and cares.<br><br>On January 11, 2023, at 9:20 a.m., regional director of operations (RDO)-D verified the medication incident and stated they are working on a performance improvement plan for medication errors.<br><br>The licensee's Medication & Treatment policy, dated August 2022, indicated the licensed nurse may administer medications if the six rights are followed to include the right person, right medication, right time, right route, right dose, and right chart.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 02040 SS=F | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:<br>(1) a hazard vulnerability assessment or safety | 02040 | | |

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| 02040 | Continued From page 15<br>risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 residents).<br><br>The findings include:<br><br>Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation.<br><br>During interview on January 12, 2023, at 11:30 a.m., the director of maintenance (DOM)-I stated they had not completed the hazard vulnerability assessment on and around the property.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 02040 | | |

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| 02040 | Continued From page 16<br>(21) days | 02040 | | |
| 02320 SS=F | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation interview and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards for four of four resident (R5, R9, R10, R11) reviewed for medication administration, call lights, and use of a mechical lift.<br><br>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).<br><br>The findings include:<br>R5 had diagnoses to include congestive heart failure (CHF) and gastroesophageal reflux (GERD), and services to include medication administration and assistance with application and removal of compression stockings. | 02320 | | |

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| 02320 | Continued From page 17<br><br>R9 had diagnoses to include dementia, and services to include medication administration, and assistance with cares.<br><br>R10 had diagnoses to include hemiplegia, and services to include assistance with cares.<br><br>R11 had diagnoses to include Congestive Heart Failure (CHF) and services to include medication management.<br><br>Medication/Treatments<br>On January 10, 2023, at 9:45 a.m., R5 stated she places her own compression wraps each morning due to wait times and lack of ULP staffing. R5 also stated her medications are often late. R5 stated she doesn't get her "acid" medication, on time, or prior to meals as scheduled.<br><br>On January 10, 2023, at 10:00 a.m., R5's compression wraps were observed to be loosely applied to R5's lower extremities. R5 stated she placed the compression wraps prior to breakfast.<br><br>Physician orders dated March 22, 2022, included orders for "compression treatment-daily-assist patient to apply compression device to bilateral lower extremities daily at 9 p.m. for control of leg edema-9PM Indicated for Leg Edema."<br><br>On January 10, 2022, at 8:30 a.m., ULP-E confirmed R5's medications are often late and stated R5 often places her own compression stockings as she doesn't want to wait for the ULP's to place the compression stockings and possibly miss breakfast.<br><br>Call lights<br>On January 10, 2023, at 9:45 a.m., R5 stated on the night shift she often puts on her call light and | 02320 | | |

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| 02320 | Continued From page 18<br>the call light is not answered and no one will show up to answer the call light.<br><br>On January 10, 2023, at 2:05 p.m., R10 stated call lights are not answered timely and she will often wait 30-45 minutes for lights to be answered. R10 indicated she was on a toileting schedule and the scheduled times are often missed or late.<br><br>On January 10, 2023, at 2:53 p.m., R11 stated call lights are not answered timely, and she was told by licensee employees that her pendant didn't work. R11 stated she did receive a new pendant, but is not confident the call lights will be answered timely.<br><br>On January 11, 2023, at 1:00 p.m., family member (FM)-J stated on December 26, 2022, R9 pushed the call light at 9:30 a.m., and the call light was not answered until 1:20 p.m. FM-J stated cameras are present in R9's apartment, so she was able to confirm the times.<br><br>The Device Activity Report dated December 25, 2022, at 12:00 a.m. to January 7, 2023, at included call light reset times of: 169 minutes on December 27, 2022, at 10:55 a.m.; 199 minutes on December 28, 2022, at 6:38 a.m.; 449 minutes on January 1, 2023, at 8:35 a.m.; 300 minutes on January 7, 2023, at 11:32 a.m.; and 351 minutes on January 7, 2023, at 11:32 a.m. The Device Activity Report included on December 26, 2022, R9's call light was reset after 225 minutes 55 seconds. The report indicated the average call light response time was 68 minutes.<br><br>Mechanical Lifts<br>On January 10, 2023, at 8:30 a.m., unlicensed personnel (ULP)-E stated she was told by | 02320 | | |

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| 02320 | Continued From page 19<br>administrative staff it was acceptable to use one assist with the EZ stand and Hoyer lift, if comfortable with use. ULP-E stated the care plans for use of the EZ stand and Hoyer lift indicated to use two staff.<br><br>On January 10, 2023, at 2:05 p.m., R10 stated she was a two-person assist with the Hoyer or EZ stand. R10 indicated "almost everyday" the ULP's will call for assist, and no one comes to assist or are too busy to assist, and the ULP's will transfer with the EZ stand or Hoyer with one ULP rather than two ULP's.<br><br>On January 11, 2023, at 9:20 a.m., regional director of operations (RDO)-D stated the EZ stand and Hoyer lift should be used with two ULP's per training and protocol. If the ULP's are unable to find another ULP to assist with transfers, they can call the administrative staff to assist. In addition, call light response time "is an issue" and "we are working on the concern, and need to get a handle on this."<br><br>The licensee's Medication & Treatment policy, dated August 2022, indicated the licensed nurse may administer medications if the six rights are followed to include the right person, right medication, right time, right route, right dose, and right chart.<br><br>The licensee's undated Mechanical Lift & Safe Patient Handling policy indicated "two staff are required for ALL mechanical lift transfers."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/10/23*
Time: 10:00:00
Report: 8041231007

# Food and Beverage Establishment Inspection Report



**Location:**
Yorkshire Of Edina Senior Lvg
7141 York Avenue South
Edina, MN55435
Hennepin County, 27

**Establishment Info:**
ID #: 0037768
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6124308125
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.

**3-500E Microbial Control: time as a control**

3-501.19A ** Priority 2 **

MN Rule 4626.0408A Develop written procedures prior to using time as a public health control for time/temperature control for safety food and maintain the procedures in the food establishment.

ESTABLISHMENT IS USING TIME AS A PUBLIC HEALTH CONTROL FOR ITEMS STORED ON ICE ON THE LINE DURING SERVICE. SUBMIT A TIME AS A PUBLIC HEALTH CONTROL PLAN TO MDH FOR APPROVAL OR STORE ALL COLD TCS FOODS USING MECHANICAL REFRIGERATION.

*Comply By: 01/10/23*

**5-200A Plumbing: approved materials/design**

5-202.12A ** Priority 2 **

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

NO HOT WATER AVAILABLE AT THE COOKLINE HAND SINK AT TIME OF INSPECTION. MAINTENANCE WAS WORKING ON REPAIR. ENSURE HAND SINK HAS BOTH HOT AND COLD RUNNING WATER FOR PROPER HANDWASHING.

*Comply By: 01/10/23*

**6-300 Physical Facility Numbers and Capacities**

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS AT THE DEMENTIA CARE HAND SINK AT TIME OF INSPECTION.

# Food and Beverage Establishment Inspection Report



*Comply By: 01/10/23*

**2-100 Supervision**

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER. STAFF HAVE SERV SAFE CERTIFICATE. CFPM APPLICATION SENT WITH REPORT.

*Comply By: 01/10/23*

**Surface and Equipment Sanitizers**

Utensil Surface Temp.: = at 181 Degrees Fahrenheit
Location: main kitchen dish machine
Violation Issued: No

Utensil Surface Temp.: = at 168 Degrees Fahrenheit
Location: dementia care dish machine
Violation Issued: No

Acid: = 272 ppm at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: service area reach-in cooler: salad
Violation Issued: No

Process/Item: Hot Holding
Temperature: 187 Degrees Fahrenheit - Location: soup well: chicken and oriental noodle
Violation Issued: No

Process/Item: TPHC
Temperature: 52 Degrees Fahrenheit - Location: on ice in steam well: coleslaw
Violation Issued: Yes

Process/Item: TPHC
Temperature: 48 Degrees Fahrenheit - Location: on ice in stream well: potato salad
Violation Issued: Yes

Process/Item: TPHC
Temperature: 50 Degrees Fahrenheit - Location: on ice in steam well: diced tomato
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: cookline reach-in cooler: sliced cheese
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: cookline reach-in cooler: turkey
Violation Issued: No

Type: Full
Date: *01/10/23*
Time: 10:00:00
Report: 8041231007
Yorkshire Of Edina Senior Lvg

# Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: mashed potato
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: pulled pork
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk-in cooler: gravy
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: dementia care cooler: sour cream
Violation Issued: No

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

Inspection was completed with Kedric Harms (Director of Dining Services). The lead Health Regulation Division Nurse Evaluator, Rhonda Makela was also on site completing site survey.

Establishment has a commercial kitchen on the first floor and a serving kitchen in dementia care.

Discussed the following:
-Employee illness policy and logging requirements
-Time as a public health control
-Glove-use and bare-hand-contact
-Cooling methods
-Food storage to prevent cross contamination
-Date marking
-Vomit clean-up procedures
-Highly susceptible population restrictions
-Thermometer calibration and temperature logs
-Violations on this report

# Food and Beverage Establishment Inspection Report



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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041231007 of 01/10/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

**Inspection report reviewed with person in charge and emailed.**

Signed:_____
Kedric Harms
Director of Dining Services

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us