Protecting, Maintaining and Improving the Health of All Minnesotans

November 7, 2023

Licensee
Keller Lake Commons
655 Norwood Lane
Big Lake, MN 55309

RE: Project Number(s) SL34175015

Dear Licensee:

On November 1, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the September 1, 2023, 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Electronically Delivered

September 27, 2023

Licensee
Keller Lake Commons
655 Norwood Lane
Big Lake, MN 55309

RE: Project Number(s) SL34175015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 1, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The 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. The 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 - 0830 - 144g.45 Subd. 3 - Local Laws Apply - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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 the 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.

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 MDH 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 the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34175015 On August 28, 2023, through August 30, 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 eighty-nine (89) and forty-five (45) active residents, all of whom received services under the Assisted Living facility license. On August 28, 2023,, at approximately 4:45 p.m. an immediate order was issued for 0830. At the time of exit, the immediacy was removed, however noncompliance will remain at the same scope and level.	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 Provider with Dementia Care. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated August 28, 2023, for the specific Minnesota Food Code deficiencies. 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	0 630		

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0 630	Continued From page 2 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 two of two residents (R4, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R4 and R6's records lacked an IAPP developed and implemented for each vulnerable adult containing the following: - 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. On August 30, 2023, at 2:27 p.m., licensed assisted living director (LALD)-C stated R4 and R6' did not have IAPPs completed until after	0 630		

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0 630	Continued From page 3 survey started. LALD-C stated, "we have updated them yesterday and this morning ... and we'd be reviewing all IAPPs and updating as needed." The licensee's Individual Abuse Prevention Plan policy dated May 12, 2022, indicated the licensee will develop and implement an individual abuse prevention plan for each vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 780 SS=E	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	0 780		

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0 780	Continued From page 4 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 interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On August 30, 2023, between 10:30 a.m. and 1:00 p.m., survey staff toured the facility with maintenance (M)-F. During the facility tour, survey staff observed the following: 1. When smoke alarms in resident room 336 were tested by M-F, these smoke alarms did not activate any of the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. 2. When smoke alarms in resident room 108 were tested by M-F, these smoke alarms did not activate any of the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate.	0 780		

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0 780	Continued From page 5 These deficient conditions were verified by M-F accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 30, 2023, between 10:30 a.m. and	0 800		

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0 800	Continued From page 6 1:00 p.m., survey staff toured the facility with maintenance (M)-F. During the facility tour, survey staff observed the following: 1. The service tag was dated July 2021 on the kitchen hood fire-extinguishing system. The kitchen hood fire-extinguishing system had not been serviced by a properly trained and qualified person at least every 6 months. 2. The laundry room doors were propped open with wedges on the second and third floors. These wedges prevented the self-closing feature of these fire-rated doors from operating properly. 3. In resident room 301, a microwave was plugged into a power strip, creating a fire hazard. 4. In resident room 130, three unapproved light-duty extension cords were being used. Additionally, an extension cord was plugged into a power strip. This improper use of extension cords and a power strip was creating a fire hazard. These deficient conditions were verified by M-F accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	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	0 810		

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0 810	Continued From page 7 (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: Based on record review and interview, the licensee failed to maintain readily available fire safety and evacuation plans; failed to provide annual training to residents capable of assisting in their own evacuation; and failed to complete the required employee evacuation drills. This 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	0 810		

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0 810	Continued From page 8 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: Survey staff requested the fire safety and evacuation plans on August 30, 2023, at approximately 12:55 p.m., from the licensed assisted living director LALD-C. During an interview, LALD-C explained that the fire safety and evacuation plans were stored in the home health aide office, which was sometimes kept locked, and that all employees had keys to this office. The licensee failed to maintain the fire safety and evacuation plans as readily available at all times within the facility. On August 30, 2023, between 1:00 p.m. and 1:45 p.m., documents were reviewed by survey staff. 1. The licensee failed to provide annual training to residents, who are capable of assisting in their own evacuation, on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The most recent resident training record was dated April 2022. 2. The licensee failed to provide records to support that the required employee evacuation drills had been performed. The fire drill planning matrix showed that drills had been scheduled for 03/08/2023 and 05/03/2023 but completed fire drill reports were not provided for these dates. The evacuation drill frequency of twice per year per shift with at least one evacuation drill every other month was not met. These deficient conditions were verified by	0 810		

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0 810	Continued From page 9 LALD-C on August 30, 2023, at approximately 1:45 p.m., during an interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R4) who was allowed by the licensee to smoke in their room. 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). This practice resulted in the issuance of an immediate correction order on August 28, 2023 The findings include:	0 830		

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0 830	Continued From page 10 The licensee held an assisted living facility license effective August 1, 2021. The licensee's health facility identification number (HFID) was 34175. The licensee was licensed for a capacity of 102 residents. R4's Individual Abuse Prevention Plan dated August 28, 2023, completed after the initiation of the survey, indicated R4 is at risk to be abused physically, financially, and emotionally. R4's IAPP did not address R4 smoking in their room. On August 28, 2023, at 1:30 p.m., the surveyor smelled cigarette smoke while inside another resident's room on second floor. On August 28, 2023, at 1:40 p.m., the surveyor and unlicensed personal (ULP-B) observed one open pack of cigarettes on small table in R4's room and ashes in an ash tray. A cigarette lighter was observed on the table. At the time of the observation, R4 was in the room. On August 28, 2023, at 1:45 p.m., ULP-B stated she smelled cigarette smoke in R4's room, but never entered R4's room since R4 did not receive any services (commonly referred to as independent"). On August 28, 2023, at 2:00 p.m., the surveyors interviewed R4. R$ stated she moved into the licensee's building in 2009, and at that time, smoking was allowed in the building. R4 stated the licensee made the building nonsmoking in 2013, but R4 was "grandfathered" in and could continue to smoke in her room. On August 28, 2023, at 2:15 p.m., licensed assisted living director (LALD)- C stated there	0 830		

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	34175	A. BUILDING: _____ B. WING _____	09/01/2023

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KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

(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
0 830	Continued From page 11 were three residents admitted prior to 2013 including R4, and they were allowed to smoke their room because they were "grandfathered" in. LALD-C stated subsequent residents signed a Smoke-Free lease. Also, LALD-C stated the three residents who were allowed to smoke in their rooms are independent and live on three different floors of the building. Minnesota state statute 144.414, subdivision 3, (a) dated 2022, indicated smoking was prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that of a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. The licensee's Smoke-Free Lease Addendum All Common Areas and Interior Apartment Units Except those units 'grandfathered in' prior to May 1, 2013, indicated "Smoke-Free Apartment: Resident agrees and acknowledges that the apartment to be occupied by Resident and members of Resident's household has been designated as a smoke-free living environment. Resident and members of Resident's household shall not smoke anywhere in the unit rented by Resident, or the building where the Resident's dwelling is located or in any of the common areas, nor shall Resident permit any guests or visitors under the control of Resident to do so." No further information provided. TIME PERIOD FOR CORRECTION: Immediate	0 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34175	A. BUILDING: _____ B. WING _____	09/01/2023

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0 830	Continued From page 12 The immediacy of the order was removed on August 29, 2023 based on supervisor review, however the scope and level remain unchanged.	0 830		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.	01470		

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01470	Continued From page 13 (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one employee records reviewed (registered nurse (RN)-E) received orientation to assisted living facility licensing requirements and regulations. 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).	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

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01470	Continued From page 14 The findings include: RN-E had a hire date of May 9,2020. RN-E's record lacked evidence of orientation to home care regulations 144G.63 subd. 2 completed prior to providing home care services to residents to include an overview Assisted Living statutes. On August 30, 2023, at 2:42 p.m., licensed assisted living director (LALD)-C stated RN-E's record lacked orientation to assisted living statutes as required. The licensee's Orientation of Staff and Supervisors and Content policy dated May 11, 2022, indicated the licensee's employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The	01640		

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01640	Continued From page 15 facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee or resident to document agreement on the services to be provided for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's signed Service Plan dated June 14, 2022, included services of bathing, behavior monitoring, meal prep, dressing, laundry, housekeeping, medication assistance, toileting, transfer assistance, and symptom screening.	01640		

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	34175	A. BUILDING: _____ B. WING _____	09/01/2023

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KELLER LAKE COMMONS	655 NORWOOD LANE BIG LAKE, MN 55309

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01640	Continued From page 16 R2's unsigned Service Plan with print date of August 29, 2023, included services of ambulation/exercise, bathing, blood glucose, vitals, behavior monitoring, meal prep, dressing, grooming, pain management, laundry, housekeeping, medication assistance, nail care, toileting, transfer assist, and transportation. R2's record lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provided by licensee after addition of services on or after June 14, 2022. On August 28, 2023, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated changes should be made to the service plan any time services change. R2's blood glucose monitoring should be on the service plan. Normally when assessments are done or anything had changed, CNS-A stated they would change the service plan. CNS-A further stated, "I guess I just missed that one." The licensee's Service Plan policy dated August 1, 2022, indicated the service plan and any revisions shall include a signature or other authentication by [the licensee] and by the resident or resident's representative, documenting agreement on the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 17 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 by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of one resident (R2.) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 28, 2023, at 12:20 p.m., unlicensed personnel (ULP)-B prepared a Novolog Flex Pen 100 U (units)/ml (milliliter) insulin pen for administration to R2. R2's insulin pen lacked a label that provided the date the medication had been opened. On August 28, 2023, at 1:00 p.m., clinical nurse supervisor (CNS)- A confirmed all insulin pens should have a prescription label and be dated when opened. The manufacturer's instructions for Novolog Flex	01890		

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01890	Continued From page 18 Pen dated June 2021, indicated the pen should be discarded after 28 days. The licensee's Insulin Preparation and Administration - Assisted Living policy dated August 15, 2022, indicated staff verify that the insulin pen is clearly labeled with the resident's name for which it is ordered for and verify provider order, the expiration date, and the number of days the pen has been open. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure prescriber orders were transcribed accurately for one of four 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	01970		

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01970	Continued From page 19 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's physician orders signed June 26, 2023, indicated oxygen at one liter per nasal cannula overnight only for sleep apnea. R3's 90-day assessment dated June 14, 2023, indicated R2 wears O2 (oxygen) at one liter at night, resident is independent with this. Staff monitor O2 sats as needed. R3's oxygen administration instruction for unlicensed personnel to follow printed on August 29, 2023, indicated oxygen at 2 LPM (liters per minute) via nasal cannula at 7:10 a.m. and 10:00 p.m. daily. R3's treatment summary for August 2023, indicated oxygen administration service was completed twice daily with R3 declining the service one time. On August 30, 2023, at 12:45 p.m., clinical nurse supervisor (CNS)-A stated R2 had signed orders from an emergency room visit on June 13, 2023, indicating R2 should be on oxygen at 2 LPM and those were the orders they went by. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

DEPARTMENT OF HEALTH

Type: Full
Date: *08/28/23*
Time: 10:40:13
Report: 1037231218

Food and Beverage Establishment Inspection Report

Location:
Keller Lake Commons
655 Norwood Lane
Big Lake, MN55309
Sherburne County, 71

Establishment Info:
ID #: 0037948
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632632363
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELLED EGGS WERE BEING STORED ABOVE READY TO EAT MACARONI SALAD. STORE ALL RAW FOODS BELOW READY TO EAT FOODS.

Comply By: 08/28/23

3-300B Protection from Contamination: cross-contamination, eggs

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

BULK CONTAINERS OF FLOUR AND SUGAR WERE NOT LABELED AT THE TIME OF INSPECTION. LABEL WITH THE COMMON NAME OF THE FOOD.

Comply By: 08/28/23

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.

ANSUL SYSTEM WAS LAST SERVICED AND TAGGED JULY 2021. SERVICE AND TAG THE ANSUL SYSTEM ANNUALLY.

Comply By: 09/28/23

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: SANITIZER BUCKET - KITCHEN
Violation Issued: No

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: SANITIZER BUCKET - SERVICECOUNTER
Violation Issued: No

Chlorine: = 100 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Prep Cooler
Temperature: 38 Degrees Fahrenheit - Location: SLICED TOMATO
Violation Issued: No

Process/Item: Hot Holding
Temperature: 144 Degrees Fahrenheit - Location: SOUP
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: ORANGE JUICE JUG
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: RICE PILAF
Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 1037231218 of 08/28/23.

Certified Food Protection Manager LINDA M ELLIS-SMITH

Certification Number: 5635 Expires: 12/14/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037231218

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 08/28/23
Time In 10:40:13
Time Out

Keller Lake Commons	Address: 655 Norwood Lane	City/State: Big Lake, MN	Zip Code: 55309	Telephone: 7632632363
License/Permit #: 0037948	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 Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	IN	(OUT)	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

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

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

GOOD RETAIL PRACTICES

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

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

		Compliance Status	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	X	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		

		Compliance Status	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		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		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:** 08/28/23

Inspector (Signature) Michelle L Hoversos