Electronically Delivered

October 20, 2022

Administrator
Eagle Street Assisted Living
12009 Eagle Street
Coon Rapids, MN 55448

RE: Project Number(s) SL20835015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 8, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

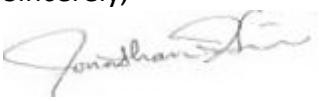
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.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

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

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

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: 651-592-5119 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20835	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE STREET ASSISTED LIVING	12009 EAGLE STREET COON RAPIDS, MN 55448

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20835015 On, September 6 through September 8, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 12 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

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0 470	Continued From page 1	0 470		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all 12 residents. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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: The licensee converted to an assisted living with dementia care license on August 1, 2021. On September 6, 2022, at 10:25 a.m., during the entrance conference, the licensee's staffing plan was requested. Licensed assisted living director (LALD)-B stated they had not developed a staffing plan. LALD-B further stated she is responsible for staff scheduling. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff;	0 500		

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0 500	Continued From page 3 (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. 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	0 500		

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0 500	Continued From page 4	0 500		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On September 6, 2022, at 7:40 a.m., the surveyor emailed the licensee that an onsite assisted living facility with dementia care survey would be initiated on September 6, 2022, at approximately 10:00 a.m. The email indicated the licensee's policies and procedures would need to be available for review.

On September 7, 2022, at 3:39 p.m., the surveyor emailed licensed assisted living director (LALD-B) with a final request for policies.

On September 8, 2022, at 10:25 a.m., LALD-B sent an email response which indicated the licensee did not have a policy or procedure for:
- medication and treatment orders;
- medication management plan;
- 30-day supervisions for unlicensed personnel;
- treatment management plan; and
- nursing assessments.

In addition, the licensee failed to provide policies and procedures to address:
- conducting and handling background studies on employees;
- conducting initial evaluations of residents' needs and the providers' ability to provide those services;
- conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or

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0 500	Continued From page 5 appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of registered nurses and licensed health professionals; and - supervision of unlicensed personnel performing delegated tasks. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post information related to the grievance procedure, resident advocacy information, and information for reporting suspected maltreatment.	0 550		

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0 550	Continued From page 6 This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 6, 2022, at approximately 11:40 a.m., during a tour of the facility, the surveyor did not observe postings in a conspicuous location and a disclosure of resident advocacy to include: -a posting with all required content of the licensee's grievance procedure and the name and email contact information for the individuals who are responsible for handling grievances; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and -number and contact information and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On September 6, 2022, at approximately 11:40 a.m., during the facility tour, registered nurse (RN)-A verified they had not posted the grievance procedure, including resident advocacy information and information for reporting suspected maltreatment. No further information was provided.	0 550		

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0 550	Continued From page 7 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) in the assisted living facility. This had the potential to affect all 12 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 640		

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0 640	Continued From page 8 The findings include: On September 6, 2022, at 11:26 a.m., the surveyor observed the common area of the facility lacked a posting of the MAARC phone number. Registered nurse (RN)-A acknowledged the MAARC phone number was not posted in the facility. The licensee's Complaints policy dated February 25, 2022, indicated, "the [licensee] must post in a visible location information about the facilities' [sic] grievance procedure," but lacked MAARC specific information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of	0 660		

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0 660	Continued From page 9 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure tuberculosis (TB) education was provided to one of two employees (unlicensed personnel (ULP)-C) reviewed for TB training. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when 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: The Facility TB Risk Assessment dated August 1, 2021, identified the facility was at a low risk for TB transmission. ULP-C's was hired on June 1, 2022. On September 6, 2022, at 1:04 p.m., registered nurse (RN)-A provided an email which indicated TB training could be found in the Educare (an online training platform) training module entitled, "OSHA and Infection Control." ULP-C's Educare education log, printed on September 6, 2022, did not include the OSHA and Infection Control training module. On September 7, 2022, at 2:05 p.m., licensed assisted living director (LALD)-B acknowledged the missing OSHA and Infection Control module	0 660		

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0 660	Continued From page 10 training from ULP-C's Educare education log. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's TB Training and Infection Control Plan policy dated July 1, 2022, indicated, "TB training is required at the time of hire and annually after that." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;	0 680		

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0 680	Continued From page 11 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all 12 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP and Emergency Handling and Use of Emergency Services documents, revised	0 680		

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	20835	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 680	Continued From page 12 on February 25, 2022, lacked individualized emergency procedures to include the following: - documented date of reviews and updates; - consider duration of interruptions; - arrangements/contracts to re-establish utility services; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care tailored to licensee's residents; - must identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a qualified person who is authorized, in writing, to act in the absence of the administrator; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop policies and procedures which address role of the [licensee] under a waiver declared by the secretary in accordance with section 1135; - develop a written communication plan and review/update annually; - must develop and maintain EP training and testing program, review/update annually; - training program must include initial EP training to policies and procedures to all new and existing staff and volunteers; - provide EP training at least annually; - maintain documentation of EP training; - demonstrate staff knowledge of EP; - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP; and - must implement emergency and standby power systems based on their EP. On September 7, 2022, at 9:28 a.m., licensed	0 680		

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0 680	Continued From page 13 assisted living director (LALD)-B acknowledged the missing information. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730		

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0 730	Continued From page 14 (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on August 30, 2016, and began receiving services under the assisted living with dementia care license on August 1, 2021.	0 730		

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0 730	Continued From page 15 R1's service plan, dated March 29, 2022, indicated R1 received services including assistance with blood glucose checks (three times daily), ostomy (a surgically created opening in the abdomen allowing waste to leave the body into a removable bag) bag emptied (daily), ostomy care (two times weekly), daily weights, showering (weekly), skin checks (three times weekly), pain assessment (daily), and hearing aides (daily). R1's record included caregiver progress notes with documentation including amount of meal eaten, and ostomy bag changed. The notes were not entered consistently and did not include consistent documentation of services provided. R3 R3 was admitted on May 26, 2020, and began receiving services under the assisted living with dementia care license on August 1, 2021. R3's service plan, dated December 19, 2019, indicated R3 received services including assistance with medication management, dressing, grooming, oral care, toileting, and bathing. R3's record included caregiver progress notes with documentation including amount of meal eaten. The notes were not entered consistently and did not include documentation of all services provided. On September 6, 2022, at approximately 3:30 p.m., licensed assisted living director (LALD)-B stated staff only documented services provided in the progress notes. LALD-B verified staff did not document every service provided.	0 730		

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0 730	Continued From page 16 The licensee's Documentation Requirements for all Services Provided policy, revised February 25, 2022, indicated, "[Licensee] requires all services provided to residents must be properly documented in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 17 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: During the facility tour on September 06, 2022, between 11:30 a.m. and 12:30 p.m. with the licensed assisted living director (LALD)-B, it was observed that all smoke alarms in resident ' s rooms were out of date. The LALD-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=D	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	0 800		

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0 800	Continued From page 18 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 September 06, 2022, between 12:00 p.m. and 12:30 p.m., survey staff toured the licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the following: 1. There is an excessive amount of lint in the laundry room around dryer. 2. There are dirty sprinkler heads in the laundry room and in front of the sprinkler riser room. 3. Electrical panel located in room 11 is missing a hinge. 4. Electrical panel is blocked but a ladder and combustible materials. LALD-B verbally confirmed survey staff observations during the facility tour. No further information was provided.	0 800		

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0 800	Continued From page 19 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 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required fire safety training for residents and staff, and failed to conduct required 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, 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). On September, 06 2022 between 11:30 a.m. to 12:30 p.m., the Licensed Assisted Living Director (LALD)-B failed to provide the following documents for review: 1. The licensee failed to provide employee training logs for fire safety and evacuation. 2. The licensee failed to provide resident training logs for fire safety and evacuation. 3. The licensee failed to provide the required employee training frequency. 4. The licensee failed to conduct required evacuation drills. The LALD-B verbally confirmed survey staff observations during the facility tour. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced	0 900		

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0 900	Continued From page 22 by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for two of two residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee converted to an Assisted Living with Dementia Care license on August 1, 2021. R1 was admitted on August 30, 2016, and began receiving services under the assisted living with dementia care license on August 1, 2021. R1's service plan, dated October 22, 2020, indicated R1 received services including assistance with blood glucose checks, medication administration, colostomy (a surgically created opening in the abdomen allowing waste to leave the body into a removable bag) care, bathing, skin checks, pain assessment, and hearing aides. R1's record included a contract titled, "[Licensee] Assisted Living Lease," signed September 4, 2018. R3 was admitted on May 26, 2020, and began receiving services under the assisted living with	0 900		

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0 900	Continued From page 23 dementia care license on August 1, 2021. R3's service plan, dated December 19, 2019, indicated R3 received services including assistance with medication management, dressing, grooming, oral care, toileting, and bathing. R3's record included a contract titled, "Homecare Services Agreement," signed December 7, 2016. R1 and R3's records lacked a current assisted living contract with the required content, signed prior to providing assisted living services. On September 6, 2022, at 2:11 p.m., licensed assisted living director (LALD)-B stated existing residents had not signed a new contract with the new assisted living licensure, but residents admitted after August 1, 2021, had been given an updated contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=E	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950		

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0 950	Continued From page 24 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for two of two residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 950		

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0 950	Continued From page 25 R1 and R3's records lacked documentation that they were provided an opportunity to designate a representative, including statutory language. The licensee converted to an Assisted Living with Dementia Care license on August 1, 2021. R1 was admitted on August 30, 2016, and received services including assistance with blood glucose checks, medication administration, colostomy (a surgically created opening in the abdomen allowing waste to leave the body into a removable bag) care, bathing, skin checks, pain assessment, and hearing aides. R1's record included a contract titled, "[Licensee] Assisted Living Lease," signed September 4, 2018. The contract lacked a form informing R1 of their right to designate a representative for certain purposes. R3 was admitted May 26, 2020, and received services including assistance with medication management, dressing, grooming, oral care, toileting, and bathing. R3's record included a contract titled, "Homecare Services Agreement," signed December 7, 2016. The contract lacked a form informing R1 of their right to designate a representative for certain purposes. On September 6, 2022, at 2:11 p.m., licensed assisted living director (LALD)-B stated existing residents had not signed a new contract or "right to designate a representative" form with the new assisted living licensure. LALD-B provided the updated contract used for new residents. The contract included a form with statutory language indicating the resident right to designate a	0 950		

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0 950	Continued From page 26 representative for certain purposes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a	01440		

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01440	Continued From page 27 delegated task within 30 days of providing services for one of one unlicensed staff (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-C was hired June 1, 2022, and provided direct care services to residents. On September 6, 2022, at 12:17 p.m. ULP-C provided catheter cares for R1. ULP-C's employee record included training forms signed on June 1, 2022, which acknowledged ULP-C received the training. ULP-C's record included a competency checklist completed on June 6, 2022. ULP-C's record lacked documentation of a 30-day supervision by a RN. On September 9, 2022, at 2:50 p.m., licensed assisted living director (LALD)-B acknowledged there had been documentation of training and competency, but there had not been documentation of a 30-day competency. The license's Competencies and Procedures List, dated February 25, 2022, lacked information for 30-day supervision by a RN.	01440		

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01440	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
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	01470		

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01470	Continued From page 29 services the employee will be providing and the facility's category of licensure. (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 interview and record review, the licensee failed to ensure one of one employee (registered nurse (RN)-A) received orientation to all required assisted living regulation content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when 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		

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01470	Continued From page 30 The findings include: RN-A was hired April 17, 2022, and provided supervisory and direct care services to the residents of the facility. RN-A's employee record lacked documentation of orientation, as outlined in MN statute 144G.63, Subd. 2, to include: - handling emergencies and using emergency services; - handling of resident/clients' complaints, reporting, complaints, where to report; and - principles of person-centered planning/service delivery. On September 7, 2022, at 2:05 p.m., licensed assisted living director (LALD)-B acknowledged RN-A's personnel chart lacked required orientation topics. The licensee's Orientation and Training List of Policies and Procedures dated February 25, 2022, indicated orientation would include handling of emergencies and use of emergency services, handling resident complaints, and person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics	01540		

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01540	Continued From page 31 specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for two of two employees (registered nurse (RN)-A, unlicensed personnel (ULP)-C). 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: The licensee was a licensed assisted living facility with dementia care (ALFDC).	01540		

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01540	Continued From page 32 RN-A RN-A was hired April 17, 2022, and provided supervision and direct care services for residents of the facility. RN-A's training and orientation records indicated 1.0 hour of dementia care training was completed on May 6, 2022, of the required eight (8) hours. On September 7, 2022, at 2:50 p.m. licensed assisted living director (LALD)-B acknowledged RN-A lacked the required eight (8) hours of dementia training. ULP-C ULP-C was hired June 1, 2022, and provided direct care services for residents of the facility. ULP-C's training and orientation records indicated 1.5 hours of dementia care training was completed on June 24, and August 3, 2022, of the required eight (8) hours. On September 7, 2022, at 2:50 p.m. LALD-B acknowledged ULP-C lacked the required eight (8) hours of dementia training. The licensee's Dementia Training Disclosure, undated, indicated "all direct care staff and their supervisors are required to take dementia training." The licensee's Orientation and Training List Policies and Procedures dated February 25, 2022, indicated in section 3.05 training was to be provided to include, "effective approaches to use to problem solve when working with resident's challenging behaviors who have dementia, Alzheimer's disease, or related disorders." No further information was provided.	01540		

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01540	Continued From page 33 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, not to exceed 90 calendar days from the last assessment date, for two of two residents (R1,	01620		

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01620	Continued From page 34 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on August 30, 2016, and began receiving services under the assisted living with dementia care license on August 1, 2021. R1's service plan, dated October 22, 2020, indicated R1 received services including assistance with blood glucose checks, medication administration, colostomy (a surgically created opening in the abdomen allowing waste to leave the body into a removable bag) care, bathing, skin checks, pain assessment, and hearing aides. R1's record included a Nursing Health and Safety Assessment created July 30, 2021. The assessment included vital sign readings dated April 7, 2021. R1's record included a Nursing Health and Safety Assessment document created March 11, 2022 (224 days after the previous assessment). The document indicated it was reviewed by RN-A June 21, 2022 (102 days after the previous assessment), and no changes were needed. The document indicated it was reviewed again by RN-A August 10, 2022, and "All appropriate changes/additions have been made." The	01620		

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01620	Continued From page 35 document indicated updated vital sign readings, but did not indicate whether all areas were comprehensively assessed, and whether previously recorded assessment information had been updated or changed. R1's record lacked a nursing reassessment, using a uniform assessment tool, completed at least every 90-days. R3 R3 was admitted on May 26, 2020, and began receiving services under the assisted living with dementia care license on August 1, 2021. R3's service plan, dated December 19, 2019, indicated R3 received services including assistance with medication management, dressing, grooming, oral care, toileting, and bathing. R3's record included a Nursing Health and Safety Assessment document created July 30, 2021. The document indicated the assessment was completed June 8, 2021 R3's record included a Nursing Health and Safety Assessment document created March 10, 2022. The document indicated the assessment was completed March 8, 2022 (273 days after the previous assessment). The document indicated the information was reviewed by RN-A June 21, 2022 (105 days after the previous assessment), and no changes were needed. The document did not indicate a comprehensive reassessment was completed on June 21, 2022. R3's record lacked a nursing reassessment, using a uniform assessment tool, completed at least every 90-days.	01620		

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01620	Continued From page 36 On September 6, 2022, at 2:37 p.m., RN-A acknowledged not all assessments were less than 90 days apart. RN-A stated she completed the March 11, 2022, assessment for R1 in person. RN-A further stated she reviewed the assessments on June 21, 2022, and had observed the resident in the facility before documenting the review. The licensee's Assisted Living Statute and Policy Overview policy, dated August 1, 2021, indicated resident reassessment and monitoring would occur 14 days after initiation of services and every 90 days thereafter or with a change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided;	01650		

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01650	Continued From page 37 (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for two of two residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on August 30, 2016, and began receiving services under the assisted living with dementia care license on August 1, 2021. R1's service plan, dated October 22, 2020, indicated R1 received services including	01650		

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01650	Continued From page 38 assistance with blood glucose checks, medication administration, colostomy (a surgically created opening in the abdomen allowing waste to leave the body into a removable bag) care, bathing, skin checks, pain assessment, and hearing aides. R3 R3 was admitted on May 26, 2020, and began receiving services under the assisted living with dementia care license on August 1, 2021. R3's service plan, dated December 19, 2019, indicated R3 received services including assistance with medication management, dressing, grooming, oral care, toileting, and bathing. R1 and R3's service plans both lacked the following: -methods of monitoring assessments -schedule and methods of monitoring staff providing services On September 6, 2022, at 11:25 a.m., registered nurse (RN)-A stated the care plan in the electronic record was not signed by the resident, and agreed the handwritten service plans were the most recent signed service plans for R1 and R3. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and	01710		

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01710	Continued From page 39 reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor and reassess the resident's medication management services at least annually for two of two residents (R1, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on August 30, 2016, and began receiving services under the assisted living with dementia care license on August 1, 2021. R1's service plan, dated October 22, 2020, indicated R1 received services including assistance with medication administration. R1's record indicated nursing assessments were completed or reviewed July 30, 2021, and March 11, June 21, and August 10, 2022. The assessments lacked a review of medication management services.	01710		

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EAGLE STREET ASSISTED LIVING	12009 EAGLE STREET COON RAPIDS, MN 55448

(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
01710	Continued From page 40 R3 R3 was admitted May 26, 2020, and began receiving services under the assisted living with dementia care license on August 1, 2021. R3's service plan, dated December 19, 2019, indicated R3 received services including assistance with medication administration. R3's record indicated nursing assessments were completed or reviewed June 8, 2021, and March 8, and June 21, 2022. The assessments lacked a review of medication management services. On September 6, 2022, at approximately 12:00 p.m., during a medication administration observation, unlicensed personnel (ULP)-C administered medications to R1 and R3. R1 and R3's records lacked monitoring and reassessment of medication management services at least annually for the following: - documentation the assessment was conducted face-to-face with the resident; - identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications On September 6, 2022, at 2:37 p.m., registered nurse (RN)-A stated she had not reviewed	01710		

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01710	Continued From page 41 medications specifically for compliance, side effects, adverse reactions, etc. RN-A further stated she had not developed a medication management plan, and the residents' nurse practitioner reviewed their medications, but she did not. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 42 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of two residents (R1). 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: R1 R1 was admitted on August 30, 2016, and began receiving services under the assisted living with	01730		

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01730	Continued From page 43 dementia care license on August 1, 2021. R1's service plan, dated October 22, 2020, indicated R1 received services including assistance with medication administration. R1's medication administration record (MAR), indicated R1 was assisted with medication administration daily September 1-6, 2022. On September 6, 2022, at approximately 12:00 p.m., during a medication administration observation, unlicensed personnel (ULP)-C administered medications to R1. R1's record lacked a medication management plan to include the following: -description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On September 6, 2022, at 2:37 p.m., RN-A stated she had not developed a specific medication management plan for the residents since her hire.	01730		

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01730	Continued From page 44 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per providers orders for two of three residents (R1, R5) with medication administration records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	01760		

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01760	Continued From page 45 only occasionally). The findings include: TRANSCRIPTION R1's service plan dated October 22, 2020, indicated R1 received services including assistance with medication administration. On September 6, 2022, at approximately 12:00 p.m., during a medication administration observation, unlicensed personnel (ULP)-C administered medications to R1, including acetaminophen. R1's medication administration record (MAR) for August 2022 and September 1-5, 2022, indicated, "ACETAMINOPHEN (TYLENOL) 500 [milligrams (mg)]--TAKE 2 TABS (1000 MG) ORALLY THREE TIMES DAILY AT 6AM, 12N, 8PM". The MAR indicated R1 was administered acetaminophen 500 mg, two tablets (1000 mg), three times daily at 6:00 a.m., 12:00 p.m., and 8:00 p.m., from August 24 through September 5, 2022. R1's record included signed orders dated August 5, 2022, indicating, "Tylenol Extra Strength Tablet 500 MG (acetaminophen) give 1000 mg by mouth every 6 hours". The record lacked any subsequent orders for acetaminophen. R1's MAR was not consistent with the current prescriber order for acetaminophen. On September 7, 2022, at 9:27 a.m., registered nurse (RN)-A stated the acetaminophen order in the MAR for R1 came from the hospital but was unable to locate documentation of the order.	01760		

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01760	Continued From page 46 MEDICATION DOCUMENTATION R5 was admitted May 3, 2019, and discharged March 18, 2022. R5 received services including assistance with medication management. R5's MAR for March 2022, indicated R5's medications included Tramadol (for pain), 50 mg, 1 tablet every 4-6 hours as needed (PRN). The MAR indicated R5 received the PRN dose of Tramadol on March 8, 2022, at 8:14 p.m. The medication was documented as administered by ULP-F. No other documentation of administration of the PRN Tramadol was recorded in the MAR for March 2022. The licensee's narcotic log book indicated R5 received PRN Tramadol March 5, 2022, at 12:50 p.m. and 7:44 p.m., March 6, 2022, at 9:00 a.m., 3:16 p.m., and 9:03 p.m., March 7, 2022 at 4:00 a.m., March 9, 2022, at 8:00 p.m., and March 11, 2022, at 10:25 a.m. R5's MAR lacked documentation of the above listed administrations of PRN Tramadol. On September 7, 2022, at 11:10 a.m., licensed assisted living director (LALD)-B acknowledged the MAR for R5 did not indicate administration of the PRN tramadol as documented in the narcotic log book. LALD-B could not say why the administration was not documented in the MAR. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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01820	Continued From page 47	01820		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for two of two residents (R1, 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) 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: R1 R1 was admitted on August 30, 2016, and began receiving services under the assisted living with dementia care license on August 1, 2021. R1's service plan dated October 22, 2020, indicated R1 received services including assistance with medication administration. On September 6, 2022, at approximately 12:00 p.m., during a medication administration observation, unlicensed personnel (ULP)-C administered medications to R1.	01820		

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01820	Continued From page 48 R1's medication administration record (MAR) for August 2022 and September 1-5, 2022, indicated R1 was administered Ensure liquid (a nutritional supplement) daily from August 8 through September 5, 2022. R1's record included a signed order dated October 8, 2020, indicating Ensure one can daily for weight loss. R1's record lacked a current prescriber order for Ensure. R1's record lacked signed provider orders for the following medications: - acetaminophen 500 milligram (mg) tablet, take two tablets by mouth (PO) three times daily at 6:00 a.m., 12:00 p.m., and 8:00 p.m.; On September 7, 2022, at 9:27 a.m., registered nurse (RN)-A stated the acetaminophen order for R1 came from the hospital but was unable to locate the order. On September 7, 2022, at 1:25 p.m., LALD-B acknowledged they lacked orders for both acetaminophen and Ensure. R3 R3 was admitted on May 26, 2020, and began receiving services under the assisted living with dementia care license on August 1, 2021. R3's service plan dated December 19, 2019, indicated R3 received services including assistance with medication administration. R3's records lacked signed provider orders for the following medications: - acetaminophen 500 mg tablet, take two tablets PO daily at 8:00 a.m., 4:00 p.m., and 8:00 p.m.;	01820		

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01820	Continued From page 49 - diclofenac sodium 1% gel, apply 2 grams (g) topically to affected area four times daily at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.; - losartan potassium 25 mg tablet, take one tablet PO daily at 7:30 a.m.; - magnesium oxide 400 mg tablet, take one tablet PO daily at 8:00 a.m.; and - metformin hydrochloride (HCL) 500 mg tablet, take 0.5 tablets PO daily at 8:00 a.m. On September 7, 2022, at 1:00 p.m., RN-A stated a fax had been sent requesting updated signed orders for R3. On September 7, 2022, at 1:05 p.m., licensed practical nurse (LPN)-E provided the medication list the licensee had faxed on September 6, 2022, at 9:46 a.m. to Twin Cities Physicians (TCP) for signature. LPN-E acknowledged the last signed comprehensive orders for R3 were in July of 2021. Both RN-A and LPN-E acknowledged the orders were not signed. The licensee's Safe Medication Assistance and Administration policy dated August 1, 2021, indicated, "prescriber's written or electronically recorded order for the prescription is sufficient to constitute written instructions from the prescriber." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=E	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and	01880		

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01880	Continued From page 50 substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored under proper temperature controls according to manufacturer instructions. This had the potential to affect two of two residents (R6, R7) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 September 7, 2022, at 2:35 p.m., the surveyor observed the medication refrigerator located in the nursing office with licensed assisted living director (LALD)-B. The refrigerator was not locked but was kept behind a locked door. There was a gray stainless steel Traceable Digital Thermometer approximately three by two by one (3x2x1) inches in size which was not functioning. Further, there wasn't a refrigerator temperature log. The refrigerator included two insulin pens, unexpired, for two current residents R6 and R7. On September 7, 2022, at 2:35 p.m., LALD-B acknowledged the thermometer was not functioning, there was no temperature log, and	01880		

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01880	Continued From page 51 the refrigerator contained two insulin pens. The licensee's Medication Storage Policy dated August 1, 2021, indicated: 1. Those medications that require refrigeration will be stored according to manufacturer's recommendations to maintain stability. 2. If the efficacy of the medication is dependent upon a stable temperature, logs will be utilized to monitor the temperature of the storage area(s). 3. Liquids should be stored in the center of the refrigerator, away from the freezer, the back wall, the bottom and not in the door. The temperature in these areas are not stable and differ from the main compartment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments	01930		

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01930	Continued From page 52 or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the policy and procedures for treatments and therapy management services included all the required content and written treatment or therapy management policies and procedures were developed under the supervision and direction of a registered nurse (RN), licensed health professional, or pharmacist consistent with current practice standards, with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked treatment or therapy management policy and procedures for requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. R1 was admitted on August 30, 2016, and	01930		

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01930	Continued From page 53 received services including assistance with blood glucose monitoring and colostomy (a surgically created opening in the abdomen allowing waste to leave the body into a removable bag) care. R3 was admitted on May 26, 2020, and received services including assistance with blood glucose monitoring. On September 6, 2022, at 4:20 p.m., during a treatment observation, unlicensed personnel (ULP)-F assisted R1 with blood glucose monitoring. On September 8, 2022, at 10:25 a.m., licensed assisted living director (LALD)-B stated they did not have policies regarding treatment orders and development of a treatment management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20835	A. BUILDING: _____ B. WING _____	09/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE STREET ASSISTED LIVING	12009 EAGLE STREET COON RAPIDS, MN 55448

(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
01940	Continued From page 54 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed and implemented a treatment or therapy management plan to include all required content for two of two residents (R1, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1	01940		

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	20835	A. BUILDING: _____ B. WING _____	09/08/2022

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01940	Continued From page 55 R1 was admitted on August 30, 2016, and began receiving services under the assisted living with dementia care license on August 1, 2021. R1's service plan, dated October 22, 2020, indicated R1 received services including assistance with blood glucose checks, and colostomy (a surgically created opening in the abdomen allowing waste to leave the body into a removable bag) care. R1's medication administration record (MAR), indicated R1 was assisted with blood glucose monitoring twice daily August 8-31, and September 1-5, 2022. On September 6, 2022, at 4:20 p.m., during a treatment observation, unlicensed personnel (ULP)-F assisted R1 with blood glucose monitoring. R3 R3 was admitted on May 26, 2020, and began receiving services under the assisted living with dementia care license on August 1, 2021. R3's MAR, indicated R3 was assisted with blood glucose monitoring daily August 1-31, 2022, and September 1-7, 2022. R3's service plan dated December 19, 2019, lacked treatment information related to assistance with blood glucose monitoring. R1 and R3's records lacked a treatment or therapy management plan to include the following: -documentation of specific resident instructions relating to the treatments or therapy administration;	01940		

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EAGLE STREET ASSISTED LIVING	12009 EAGLE STREET COON RAPIDS, MN 55448

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01940	Continued From page 56 -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On September 6, 2022, at 2:37 p.m., RN-A stated she had not developed a specific treatment or therapy management plan for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards	02040		

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EAGLE STREET ASSISTED LIVING	12009 EAGLE STREET COON RAPIDS, MN 55448

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02040	Continued From page 57 identified on and around the property. Mitigation of property hazards to protect residents from harm was not included. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 06, 2022, at approximately 12:30 p.m., the licensed assisted living director (LALD)-B confirmed during the exit interview that the facility failed to include safety risks or hazards identified on and around the property in the assessment. They also confirmed that mitigation of property hazards to protect residents from harm had not been completed. The LALD-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided	02110		

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	20835	A. BUILDING: _____ B. WING _____	09/08/2022

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EAGLE STREET ASSISTED LIVING	12009 EAGLE STREET COON RAPIDS, MN 55448

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02110	Continued From page 58 based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents' legal and designated representatives at the time of move for residents (R1, R3).	02110		

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02110	Continued From page 59 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: R1 was admitted August 30, 2016, and began receiving services under the assisted living with dementia care license on August 1, 2021. R3 was admitted May 26, 2020, and began receiving services under the assisted living with dementia care license on August 1, 2021. R1 and R3's records were reviewed and lacked documentation residents' or designated representatives were provided with updated dementia training disclosure to include policies and procedures required as of August 1, 2022, for Assisted Living Facility with Dementia Care (ALFDC) license. On September 7, 2022, at 1:14 p.m., licensed assisted living director (LALD)-B stated all residents of the licensee, who were admitted both before and after August 1, 2022, were not provided with the updated dementia training disclosure and policies and procedures. The licensee's Dementia Training Disclosure, undated, indicated required dementia training but lacked information to address dementia policies. No further information was provided.	02110		

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02110	Continued From page 60 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *09/15/22*
Time: 12:13:16
Report: 8087221185

Food and Beverage Establishment Inspection Report

Location:
Eagle Street Assisted Living
12009 Eagle Street
Coon Rapids, MN55448
Anoka County, 02

Establishment Info:
ID #: 0038293
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7638621627
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 18 Degrees Fahrenheit - Location: SANYO STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: SUPERIOR STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: SOUP
Temperature: 39 Degrees Fahrenheit - Location: SUPERIOR STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: SUPERIOR STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 38 Degrees Fahrenheit - Location: SUPERIOR STAND-UP COOLER
Violation Issued: No

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH HFE-NURSE EVALUATOR II RENEE ANDERSON.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

Food and Beverage Establishment Inspection Report

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS 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 8087221185 of 09/15/22.

Certified Food Protection Manager: JOHN P. POLITTE

Certification Number: 7604 Expires: 09/26/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
JOHN P. POLITTE
PERSON IN CHARGE

Signed: _____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us