Electronically Delivered

May 5, 2023

Licensee
Diane's Place LLC
10300 180th Lane Northwest
Elk River, MN 55330

RE: Project Number(s) SL36845015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36845	A. BUILDING: _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIANE'S PLACE LLC	10300 180TH LANE NW ELK RIVER, MN 55330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36845015-0 On April 17, 2023, through April 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 5 residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 17, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=F	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	0 660		

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0 660	Continued From page 2 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 compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a facility TB risk assessment, documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two employees (registered nurse (RN)-B, 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 660		

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0 660	Continued From page 3 On April 17, 2023, at 12:45 p.m., the licensee's TB risk assessment indicated the licensee was a low risk. RN-B RN-B had a start date of November 26, 2018. RN-B's record lacked evidence of the following: - Two-step TST or blood test. ULP-C ULP-C had a start date of November 19, 2020. ULP-C's record lacked evidence of the following: - Health history and symptom screen; and - Two-step TST or blood test. On April 19, 2023, at 11:20 a.m., licensed assisted living director (LALD)-A confirmed the required content listed above was not in RN-B or ULP-C's employee record. LALD-A stated, "due to covid, we did not complete TB screening." The licensee's Tuberculosis Screening/Prevention policy dated July 22, 2021, indicated baseline TB screening at the time of hire would be required for all Health care Workers in Minnesota, and would consist of three components: (1) assessing for current symptoms of active TB disease, and (2) assessing TB history and (3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single blood test. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with	0 660		

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0 660	Continued From page 4 patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." 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; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 5 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 observation, 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 residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 17, 2023, at 12:15 p.m., licensed assisted living director (LALD)-A provided an Emergency Preparedness binder, and indicated licensee was actively fixing the EP binder due to the findings of a recent survey at licensee's other facility. The licensee's EP plan dated August 1, 2021, lacked: - documentation of annual review; - process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - process for arrangements with other facilities/providers to receive residents in the event of limitation/cessation of operations to	0 680		

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0 680	Continued From page 6 maintain the continuity of services to residents; - policies and procedures on volunteers; and - emergency prep training and testing as required per Appendix Z. In addition, the licensee failed to: - post the EP plan in a prominent area of the facility; - provide residents with exit diagrams; and; - post emergency exit diagrams on each floor. On March 17, 2023, at 11:30 p.m., LALD-A stated, " we realize our EP plan is not up to date, we thought we had everything the EP entailed because we received our policies from Home Care Consultants." LALD-A confirmed the licensee's emergency preparedness plan lacked the above listed required content, and was not aware of the required content of Appendix Z. The licensee's Emergency Preparedness policy dated July 22, 2021, indicated EP references from CMS State Operations Manual Appendix Z. Additionally, the EP plan/program would be reviewed/updated at least annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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;	0 810		

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0 810	Continued From page 7 (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. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, 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	0 810		

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0 810	Continued From page 8 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: A record review and interview were conducted on April 18, 2023, at approximately 2:45 p.m. with Licensed Assisted Living Director (LALD)-A and Registered Nurse (RN)-B on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or	0 810		

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0 810	Continued From page 9 evacuate residents or identify the unique and unusual needs of the residents. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the only drills were not conducted every other month and failed to provide two drills on second shift and two drills on third shift. During interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or	0 970		

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0 970	Continued From page 10 unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 17, 2023, at 12:32 p.m., licensed assisted living director (LALD)-A provided a blank Assisted Living Contract and indicated it was the current contract used by licensee for all residents who lived in the facility. The licensee's Assisted Living Contract, undated, on page 15, included a section titled 2. Indemnification and read, " Resident will indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the rented premises or	0 970		

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0 970	Continued From page 11 any other part of Provider's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." Additionally, the licensee's Assisted Living Contract included a section titled 4. Liability and read, "Provider is not liable to Resident for any injury, death or property damage occurring in the Unit or on Provider's premises." On March 17, 2023, at 1:25 p.m., LALD-A confirmed the licensee's assisted living contract included a waiver of liability for health and safety or personal property of the resident. LALD-A stated the licensee was working on getting the contract revised and having the residents sign a revised contact without the liability language within the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01290 SS=C	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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01290	Continued From page 12 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the assisted living with dementia care licensee's current health facility identification (HFID) for two of two employees (registered nurse (RN)-B, unlicensed personnel (ULP))-C). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: RN-B RN-B was hired on November 26, 2018, to perform care and services for residents of the Assisted Living with Dementia Care Facility. RN-B's employee record included a background study clearance, affiliated with the licensee's former comprehensive HFID license #32771. RN-B's employee record lacked evidence of current, cleared background studies affiliated with the licensee's current assisted living with dementia care HFID license #36845, effective August 1, 2021.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36845	A. BUILDING: _____ B. WING _____	04/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 13 ULP-C ULP-C was hired on November 19, 2020, to perform care and services for residents of the Assisted Living with Dementia Care Facility. On April 18, 2023, at 8:45 a.m., the surveyor observed ULP-C administer medication to R2. ULP-C's employee record included a background study clearance, affiliated with the licensee's former comprehensive HFID license #32771. ULP-C's employee record lacked evidence of current, cleared background studies affiliated with the licensee's current assisted living with dementia care HFID license #36845, effective August 1, 2021. On April 18, 2023, at 9:47 a.m., licensed assisted living director (LALD)-A indicated the background studies for licensee's employees were conducted under licensee's former comprehensive HFID license #32771 versus the new assisted living license HFID #36845. LALD-A stated licensee was aware of the problem, and was working with the Minnesota Department of Health and Department of Human Services to get the correct HFID # on employee background clearance studies. The licensee's Recruitment and Hiring policy dated July 22, 2021, indicated licensee complies with all state regulations for pre-employment background checks/studies required for all employees. Additionally, all new hires must have a completed background prior to having contact with residents. No further information was provided.	01290		

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01290	Continued From page 14 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=E	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) completed a timely comprehensive reassessment using the uniform assessment tool for two of two residents (R2, R3) as required.	01620		

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01620	Continued From page 15 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 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: R2 R2 was admitted February 15, 2021, and had diagnoses to include dementia, major depressive disorder, hypoglycemia, asthma, hypercholesterolemia, irritable bowel syndrome, chronic obstructive pulmonary disease, fibromyalgia, idiopathic hypotension, bipolar disorder, and insomnia. R2's Service Plan-Addendum to Contract effective March 7, 2023, included assistance with ambulation, exercise, bathing, dressing, grooming, medication administration, vital signs, laundry, housekeeping, tolieting reminder, meal reminder, safety checks, and behavior management. R2's ongoing resident reassessments were completed on November 14, 2022, and February 14, 2023, two days after the required 90-day reassessment date. R3 R3 was admitted January 27, 2022, and had diagnoses to include chronic obstructive pulmonary disease, emphysema, asthma, recovery alcholic, hypertension, ascites-chronic,	01620		

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01620	Continued From page 16 cirrhosis of the liver due to alcohol, alcohol dependence, uncomplicated, generalized anxiety disorder, major depressive disorder, and malnutrition. R3's Service Plan-Addendum to Contract effective March 7, 2023, included assistance with medication administration, vital signs, laundry, housekeeping, abdominal measurements, bathing reminder, meal reminder, and safety checks. R3's 14-day reassessment was completed on February 2, 2022, and 90-day reassessment was completed on May 12, 2022, three days after the required 90-day reassessment date. During an interview on April 18, 2023, at 12:20 p.m., registered nurse (RN)-B confirmed 90-day reassessment's of R2 and R3 were not completed timely. RN-B stated, "when priorities come up, I do what I have to do to take care of my resident's." The licensee's Assessment and Reassessment policy dated July 22, 2021, indicated ongoing resident reassessments would be conducted by an RN and would not exceed 90 days from the last date of the previous assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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	02040		

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02040	Continued From page 17 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 record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability 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). Findings include: A record review and interview were conducted on April 18, 2023, at approximately 1:50 p.m. with Licensed Assisted Living Director (LALD)-A and Registered Nurse (RN)-B on the hazard vulnerability assessment for the physical environment of the facility.	02040		

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02040	Continued From page 18 During interview, LALD-A verified that the licensee had not done a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=C	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 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;	02110		

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02110	Continued From page 19 (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 the assisted living facility with dementia care provided the required policies and procedures to two of two residents (R2 and R3) and the residents' legal and designated representatives at the time of move-in. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings included: R2 R2 admitted to licensee on February 15, 2021. R2's diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life). R2's record lacked documentation of receipt of required policies and procedures to be provided to the residents and the residents' legal and designated representatives at the time of move-in.	02110		

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02110	Continued From page 20 R2's most recent Service Plan-Addendum to Contract was signed by R2 and R2's designated representative on March 15, 2023. R3 R3 admitted to licensee on January 27, 2022. R3's diagnoses included chronic obstructive pulmonary disease (COPD), emphysema, asthma, hypertension, cirrhosis of the liver, generalized anxiety disorder, malnutrition, and depressive disorder. R3's record lacked documentation of receipt of required policies and procedures to be provided to the residents and the residents' legal and designated representatives at the time of move-in. R3's most recent Service Plan-Addendum to Contract was signed by R3 on March 8, 2023. On April 19, 2023, at 10:00 a.m., surveyor requested a copy of the signed documentation and policies and procedures the licensee provided to R2 and R3 or their designated representatives at the time of their move in. Licensed assisted living director (LALD)-A stated R2 and R3 signed an acknowledgement, located on their most recent service plans, indicating R2 and R3 had received a copy of the Dementia Training Disclosure/Dementia Program Disclosure. On April 19, 2023, at approximately 11:00 a.m., LALD-A provided surveyor with a copy of the Dementia Training Disclosure/Dementia Program Disclosure, which R2 and R3 and their legal and designated representative received. The Dementia Training Disclosure/Dementia Program Disclosure lacked the required policies and	02110		

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02110	Continued From page 21 procedures including; -Medication Management Services; -Assisted Living with Memory Care Dementia Training; -Description of Life Enrichment Programs and how activities are implemented; -Behavioral Symptoms and Interventions in ALDC; -Family Support and Engagement; -Safekeeping of Resident's Possessions in ALDC; -Transportation Coordination and Assistance; -Wandering and Egress Prevention in ALDC; -Philosophy of Service Provision; and -Use of Public Address and Intercom Systems in ALDC; On April 19, 2023, at 11:23 a.m., during an interview with LALD-A and RN-B, RN-B stated, "we do not have anything else specific regarding dementia policies except for the ones I already gave you." The licensee's Policies Specific to Assisted Living with Dementia Care policy dated July 22, 2021, indicated policies and procedures shall be provided by the licensee to the resident and the resident's legal and designated representatives at the time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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

Type: Full
Date: *04/17/23*
Time: 11:10:46
Report: 7930231086

Food and Beverage Establishment Inspection Report

Location:
Diane'S Place Llc
10300 180th Lane Nw
Elk River, MN55330
Sherburne County, 71

Establishment Info:
ID #: 0037474
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634441881
ID #:

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

The following orders were issued during this inspection.

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

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

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

RAW EGGS WERE STORED ABOVE VEGETABLES IN THE UPRIGHT COOLER. ALL RAW EGGS SHOULD BE STORED ON THE BOTTOM SHELF AWAY FROM ANY READY TO EAT FOODS.

Comply By: 04/17/23

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

LIKE STATED ABOVE. THE FOLLOWING ITEMS ARE PAST THE DATE AND NEED TO BE DISCARDED: ROAST BEEF 3/27, SALAMI 4/5, PEPPERONI 4/5, TURKEY BREAST 4/5 AND CHEDDAR BRATS 3/27. ONCE PACKAGE IS OPENED, DISCARD WITHIN 7 DAYS.

Comply By: 04/17/23

2-100 Supervision

2-102.11JKLMO ** Priority 2 **

MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper

Food and Beverage Establishment Inspection Report

use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.

REMOVE THE FOOD SAVER REDUCED OXYGEN PACKAGING MACHINE FROM ESTABLISHMENT. REDUCED OXYGEN PACKAGING CAN NOT BE DONE UNLESS YOU HAVE A HACCP PLAN AND COMMERCIAL EQUIPMENT TO DO SO. FOOD SAVERS ARE NOT APPROVED.

Comply By: 04/17/23

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: ROAST BEEF--UPRIGHT COOLER
Violation Issued: No

Process/Item: Cooking
Temperature: 197 Degrees Fahrenheit - Location: BEEF--USED IN BEEF STROGANOFF
Violation Issued: No

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

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 7930231086 of 04/17/23.

Certified Food Protection Manager CHRISTINE L. COOK

Certification Number: 111243 Expires: 05/05/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us