DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

November 16, 2022

Administrator
Lifestone Health Care, Inc.
319 7th Street
Proctor, MN 55810

RE: Project Number(s) SL32149015

Dear Administrator:

On November 14, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the August 25, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, RN, BSN
Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

Electronically Delivered

September 9, 2022

Administrator
Lifestone Health Care, Inc.
319 7th Street
Proctor, MN 55810

RE: Project Number(s) SL32149015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 25, 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, the following fines are assessed pursuant to this evaluation:

St - 0 - 1350 - 144g.60 Subd. 5 - Temporary Staff = $3,000
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $6,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-5175 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32149	A. BUILDING: _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTONE HEALTH CARE INC	319 7TH STREET PROCTOR, MN 55810

(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 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: SL32149015 On, August 22, 2022, through August 25, 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 eight (8) residents, all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on August 23, 2022, tag identification 2310 and a second immediate correction order was identified on August 24, 2022, tag identification 1350, both issued for SL32149015. On August 25, 2022, the immediacy of correction orders 1750 and 2310 was removed, however non-compliance remained at a scope and level of I for both orders.	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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director/registered nurse (LALD/RN)-A was listed as the Director of Record for the licensee. This had the potential to affect all eight (8) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD/RN-A obtained an assisted living director license on August 6, 2021. On August 22, 2022, at approximately 9:29 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD/RN-A held a current assisted living director license. The BELTSS website did not indicate LALD/RN-A as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 During the entrance conference on August 22, 2022, at approximately 9:33 a.m., LALD/RN-A identified herself as being the LALD for the facility. No further information was provided. TIME PERIOD FOR CORRECTIONS: Two (2) days	0 110		
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 post the required content in common areas to include posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all eight (8) residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 640		

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0 640	Continued From page 3 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During a facility tour on August 22, 2022, at approximately 12:23 p.m., the surveyor confirmed with licensed assisted living director/registered nurse (LALD/RN)-A, the licensee had a cordless phone in the kitchen that was available for resident use if needed. LALD/RN-A confirmed there were no postings or 911 emergency number in common areas or near the phone in the kitchen. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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	0 680		

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0 680	Continued From page 4 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 observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all eight (8) residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 22, 2022, at approximately 9:33 a.m., the surveyor	0 680		

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0 680	Continued From page 5 requested the licensee's emergency preparedness plan. During the facility tour with licensed assisted living director/registered nurse (LALD/RN)-A and unlicensed personnel (ULP)-D on August 22, 2022, at approximately 12:23 p.m., the surveyor observed the main entrance and common areas of the facility lacked signage posted or information regarding the licensee's emergency preparedness plan. LALD/RN-A stated the emergency plan was posted in areas throughout the building and referred to the emergency evacuation diagrams. The licensee's Emergency Action Plan lacked the following content and/or policies and procedures to address: - a completed risk assessment; - policies and procedures to address natural and man-made disasters - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a missing resident plan that was reviewed quarterly; - arrangements/contracts to re-establish utility services; - a description of the population served by the licensee; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included staff	0 680		

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0 680	Continued From page 6 responsibilities during an evacuation and transporting services for residents being evacuated; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, ombudsman, state licensing and certification agencies; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On August 23, 2022, at approximately 11:30 p.m., LALD/RN-A confirmed she was not familiar with the Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). LALD/RN-A stated the	0 680		

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0 680	Continued From page 7 licensee had an emergency plan and policies but did not have the contents of the license's emergency preparedness plan pulled all together in one place and available to review. LALD/RN-A had provided the surveyor with the licensee's Plans for Natural Disasters and Emergencies policy dated August 1, 2021, and stated that was the licensee's emergency plan along with the emergency exits signs, and signs of what to do in the event of a fire or sever weather. The licensee's Plans For Natural Disasters And Emergencies policy dated August 1, 2021, indicated the LALD was responsible for the development of the agency's written plan of action to address the clients' care and services in response to a natural disaster or another type of emergency that may affect the licensees ability to provide services. The plan would be updated regularly and would be coordinate with local emergency responders, with the management of the facility. No further information was 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	0 730		

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0 730	Continued From page 8 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; (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:	0 730		

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0 730	Continued From page 9 Based on interview and record review, the licensee failed to ensure a resident record included a discharge summary for one of one discharged resident (R2) with record 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: On August 22, 2022, at approximately 9:33 a.m., during entrance conference, the surveyor requested a list of the licensee's discharge residents for the past six months. Licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee had only one resident discharge. Later that day, LALD/RN-A provided the surveyor a Discharge Resident/Client Roster dated from February 1, 2022, to August 22, 2022. The licensee's Discharge Resident/Client Roster list dated February 1, 2022, to August 25, 2022, indicated R2's services started November 8, 2021, and was discharged August 22, 2022, due to a change in level of care. R2's diagnosed included major depressive disorder. R2's record lacked evidence a discharge summary was completed. On August 23,2022, at approximately 11:30 a.m.,	0 730		

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0 730	Continued From page 10 LALD-A confirmed R2's discharge date on the Discharge Resident/Client Roster provided to the surveyor was incorrect and stated R2 went into the hospital on April 5, 2022 and was officially discharged from the facility on April 28, 2022. LALD-A stated she had not completed a discharge summary for R2 and considered email correspondences with R2's county case worker R2's discharge summary. No further information provided. TIME PERIOD OF CORRECTION: Twenty-One (21) days	0 730		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers for the facility. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a	0 790		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTONE HEALTH CARE INC	319 7TH STREET PROCTOR, MN 55810

(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
0 790	Continued From page 11 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 22, 2022, between 10:00 a.m. and 11:00 a.m., survey staff toured the facility with the licensed assisted living director/registered nurse (LALD/RN)-A and the program manager (ULP)-D. During the facility tour, survey staff observed that the portable fire extinguishers were provided with inspection/maintenance tags, but these tags were not from a certified company. The LALD/RN-A explained during the tour interview that supervisors from the facility perform inspections of the fire extinguishers and record the dates on the tags. The LALD/RN-A further explained that a certified company had not been performing annual maintenance on the fire extinguishers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 22, 2022, between 10:00 a.m. and 11:00 a.m., survey staff toured the facility with the licensed assisted living director/registered nurse (LALD/RN)-A and the program manager (ULP)-D. During the facility tour, survey staff observed a fence that surrounded the outdoor activity space for residents with a gate door that was held in place with a strap. The LALD/RN-A could not open this gate door during the tour. On August 22, 2022, during the facility tour, the LALD/RN-A confirmed during an interview that the gate door required repair. No further information was provided. 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	0 810		

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0 810	Continued From page 13 (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. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide the required plans for fire safety and evacuation. This had the potential to directly affect all residents and staff.	0 810		

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0 810	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 22, 2022, at approximately 11:00 a.m., the program manager (ULP)-D provided documents for review. Documents were reviewed by survey staff on August 22, 2022, between 11:00 a.m. and 11:45 a.m. The Fire Safety and Evacuation Plan Procedure dated 9-14-21 failed to include the identification of unique or unusual resident needs for movement or evacuation. On August 22, 2022, at approximately 11:50 a.m., the licensed assisted living director/registered nurse (LALD/RN)-A explained during an interview the procedures that would be followed for movement and evacuation of residents with unique or unusual needs. The LALD/RN-A confirmed that these procedures needed to be added to the written plans for fire safety and evacuation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact	0 930		

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0 930	Continued From page 15 information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R1) with records reviewed. This had the potential to affect all eight (8) 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 August 22, 2022, at approximately 9:00 a.m.,	0 930		

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0 930	Continued From page 16 during the entrance conference, the surveyor requested a copy of the facility's assisted living contract. R1's diagnoses included spinal stenosis with falls, epilepsy, anxiety, cognitive disorder, dysphagia (difficulty swallowing), and type II diabetes. R1's Assisted Living Services and Housing Contract Agreement dated August 2, 2022, lacked the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer. R1's Client Individual Service/Care Plan date July 26, 2022, indicated R1 received the following services: medication management, treatment services, assistance with eating, transferring, bathing, grooming, laundry, housekeeping. On August 23, 2022, at approximately 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A confirmed the same assisted living contract was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 970 SS=C	144.50 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 17 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 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all eight (8) 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 August 22, 2022, at approximately 9:00 a.m., during the entrance conference, the surveyor requested a copy of the facility's assisted living contract. The assisted living contract provided included a clause that indicated the resident would waive the facility's liability for health, safety, or personal property of the resident. Page 6, section M. under II. The Company makes no representations or guarantees that the Company is secure from theft or and other criminal act perpetrated by any other Client or person; therefore, the Company recommends that valuables, including but not limited to, jewelry and large amounts of money,	0 970		

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0 970	Continued From page 18 not be brought into the Company. If the Client chooses to bring in such valuables, Client is doing so at own risk and the Company will not be responsible for any theft or loss of these items. On August 23, 2022, at approximately 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A confirmed the same assisted living contract was used for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

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01060	Continued From page 19 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to provide written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation for one or one resident (R2) 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 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:	01060		

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01060	Continued From page 20 The licensee's Discharged Resident/Client Roster dated, February 1, 2022, to August 22, 2022, indicated R1 was admitted on November 8, 2021, and was discharged August 22, 2022, to the clinic for a change in level of care. R2's record lacked a discharge summary. Emails from licensed assisted living director/registered nurse (LALD/RN)-A to county social worker (CSW)-I on April 27, 2022, confirmed R2 went to the hospital on April 5, 2022, and indicated R2 had a care conference via telephone to discuss if R2 was appropriate for discharge back to the licensee or another provider which would be further discussed. On April 28, 2022, LALD/RN-A received an email from SW-J indicating R2 refused to return to the licensee and R2 was receptive relocating to another provider and receive mental health care support. On April 28, 2022, LALD/RN-A responded to the previous email indicating R2 had been officially discharged from the licensee. R2's Care Coordination Note dated April 28, 2022, indicated R2 refused to return to the facility, was discharge from the facility to another facility (unknown date) and medications would be destroyed since resident was in the hospital. R2's Medication Disposal Log indicated R2's moved out and R2's medications were disposed of May 1, 2022, and May 13, 2022. The licensee lacked documentation providing a reason for the relocation, and a written notice providing the required minimums: -reason for relocation; -name and contact information for the location to which the resident has been relocated and any	01060		

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01060	Continued From page 21	01060		

new service provider;
-contact information for the Office of Ombudsman for Long-Term Care;
-if known and applicable the approximate date or range or dates within which the resident is expected to return or a statement the return date is unknown;
-a statement if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144.54. The facility must provide contact information for the agency to which the resident may submit an appeal;
-the notice) must be delivered as soon as practicable to:
-the resident, legal representative, and designated representative;
-for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager;
-the Office of Ombudsman for Long-Term Care if the resident has been relocated.

On August 23, 2022, at approximately 11:30 a.m., LALD/RN-A confirmed R2 was sent into the hospital on April 5, 2022, and not on August 22, 2022, as the licensee's discharge roster indicated. LALD/RN-A stated R2 was sent to the hospital for change in mental health and remained in the hospital until the licensee discharged R2 on April 28. 2022. LALD/RN-A confirmed the OOLTC had not been notified of R2's hospitalization because R2's hospitalization was not considered an emergency relocation.

The licensee's Office of Ombudsman For Long-Term Care (OOLTC) policy dated August 1, 2021, indicated the LALD or designated staff would ensure all required documents were

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01060	Continued From page 22 submitted to the OOLTC by fax or email to include Notice of Emergency Relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01350 SS=I	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure contracted staff met all requirements for training and competency evaluation, as identified in 144G.60, Subd. 4 and 144G.61 Subd 1. and 2, for one of one unlicensed personnel (ULP-E) with records reviewed. This had the potential to affect all residents recieving medication administration. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This resulted in an immediate correction order on August 24, 2022, at approximately 1:25 p.m.	01350		

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01350	Continued From page 23 The findings include: During the entrance conference on August 22, 2022, at approximately 9:33 a.m., licensed assisted living director/registered nurse (LALD/RN)-A confirmed the licensee utilized contracted ULPs to maintain staffing for the facility. ULP-E started work for the licensee on August 22, 2022, and was on the only staff scheduled to work August 22, 2022, through August 25, 2022, from 3:00 p.m. to 11:00 p.m., and was responsible for medication administration for all residents recieving medication administration during the hours identified. On August 22, 2022, at approximately 3:20 p.m., the surveyor observed ULP-D direct ULP-E in setting up resident medications from medication planners into clear plastic condiment-like containers to later administer. On August 22, 2022, at approximately 4:14 p.m., ULP-D stated she was a registered CNA and trained other new staff for the licensee. On August 22, 2022, at approximately 4:32 p.m., ULP-E stated she was a traveling CNA and that day was her first time working for the licensee. ULP-E stated every facility trains differently: however, she was used to having the registered nurse complete training with a check-off list. R1's August 2022 Medication Administration Record, indicated on August 22, 2022, R1 received the following medications from ULP-E at 4:00 p.m.: -Refresh Tears 0.5-0.9% one drop in each eye;	01350		

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01350	Continued From page 24 -hydromorphone 2 milligrams (mg) one tablet by mouth; R1's August 2022 Medication Administration Record, indicated on August 22, 2022, R1 received the following medications from ULP-E at 8:00 p.m.: -Latanoprost 0.005% solution one drop in each eye; -Refresh Tears one drop in both eyes; -Hydromorphone 2 mg one tablet by mouth; -acetaminophen 325 mg two tablets by mouth; -gabapentin 600 mg one tablet by mouth; -lorazepam 0.5 mg one tablet by mouth; and -quetiapine 25 mg one tablet by mouth. On August 24, 2022, at approximately 9:30 a.m., LALD/RN-A confirmed ULP-E was trained by ULP-D on medication administration and LALD/RN-A did not complete a competency evaluation for ULP-E's training. LALD/RN-A stated she would normally assist along with ULP-D in training new staff but at that time was busy with the survey. LALD/RN-A stated she was at the facility during ULP-E shift and was available if needed. LALD/RN-A stated ULP-E was a registered certified nursing assistant and had already received the appropriate training and was assured by the temporary staffing agency providing the staff also provided the required training and competency evaluations. On August 24, 2022, at approximately 11:08 a.m., ULP-D confirmed she provided ULP-E's orientation to the facility and residents and trained ULP-E on medication administration. The licensee's Training and Competency Evaluation of Unlicensed Staff dated August 1, 2021, indicated training and competency	01350		

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01350	Continued From page 25 evaluations of ULPs must be conducted by a RN or other instructor in conjunction with the RN. Other Licensed Health Professionals may train and conduct competency evaluations of ULPs for task that can be delegated by the Licensed Health Professional within his/her professional scope of practice (e.g., assigned therapy tasks). The licensee's policy Administration of Medications by Unlicensed Personnel dated August 1, 2021, indicated ULPs that satisfied the training requirements, have been determined competent to follow the procedures and have been delegated the responsibility by the RN, may administer medications. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy is removed as confirmed by review of plan of correction by evaluation supervisor on August 25, 2022, however, noncompliance remains at a scope and severity of level three, widespread (I). TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each	01460		

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01460	Continued From page 26 staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees, (licensed assistive living director/registered nurse (LALD/RN)-A) employee record contained orientation to assisted living facility licensing to include all the required topics 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: During entrance conference on August 22, 2022, at approximately 9:33 a.m., LALD/RN-A confirmed she was responsible for maintaining employee records. LALD/RN-A had a hire date of September 12, 2013, under the licensee's former home care license and continued to provide and supervise direct care services under the assisted living license on August 1, 2021. LALD/RN-A 's employee record lacked the following required orientation content: - an overview of the 144G statutes; - policies and procedures related to the provision of assisted living services by the individual staff	01460		

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01460	Continued From page 27 person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of emergencies and use of emergency services; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - 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 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 24, 2022, at approximately 1:42 p.m., LALD/RN-A stated she completed assisted living orientation through required trainings through the Minnesota Department of Health (MDH) as part of the change of the new assisted living licensing. LALD/RN-A stated she would have to go through her emails and print off the documentation of the orientation to assisted living webinar training's she attended. On August 26, 2022, at 6:11 p.m., LALD/RN-A provided via email to the evaluation supervisor, which included attachments to include: an attestation from LALD/RN-A indicating the initial licensing education requirement grandfathered some individuals for the LALD, as well as screen	01460		

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01460	Continued From page 28 shots of various teleconference presentation provided by MHD related to: Presentation on Appendix Z Part 2, Training Requirements, Department of Human Services updates, Plan Review and Site Visits, Appeals Process, Surveys, LALD Updates, Resident Quality of Care Outcomes Improvement Task Force, Review of survey findings, Change of Ownership, Closures, Assisted Living Licensure (ALL) Overview, ALL Renewal Application and ALL Renewal Process. However, none of the information provided was specific to the licensee and did not meet the orientation requirements under Chapter 144G.63, Subd. 1. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
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;	01470		

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01470	Continued From page 29 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (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.	01470		

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01470	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of one employee unlicensed personnel (ULP)-D 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 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-D had a hire date of July 11, 2022, to provide direct care services to the license's residents. ULP-D's Nurse Orientation and Training Documentation indicated ULP-D completed Home Care Orientation on July 23, 2022, and reviewed the Minnesota Bill of Rights for Assisted Living Residents July 11, 2022. ULP-D's employee record lacked the following required orientation content: - an overview of the 144G statutes; -policies and procedures related to the provision of assisted living services by the individual staff person; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and	01470		

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01470	Continued From page 31 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 22, 2022, at approximately 3:58 p.m., ULP-D was observed assisting R1 transfer from his wheelchair to bed with the use of a mechanical lift device. On August 24, 2022, at approximately 1:42 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she believed the Orientation to Home Care Services included the required content noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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	01530		

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01530	Continued From page 32 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 one of two employees (unlicensed personnel (ULP)-D) received the dementia care training in the required time frame with records reviewed. This had the potential to affect all eight (8) 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 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 finding include: ULP-D was hired on July 11, 2022, to provide direct care services to the licensee's residents. On August 22, 2022, at approximately 3:58 p.m., ULP-D was observed assisting R1 transfer from his wheelchair to bed with the use of a mechanical lift device.	01530		

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01530	Continued From page 33 ULP-D's employee records did not indicate a total of 8 hours of the required dementia training was completed within 160 hours of the employee's start date. ULP-D's employee record indicated ULP-D completed dementia care training from 40 Essential In-Services for Home Health: Lesson Plans and Self-Study Guides for Aides and Nurses, dated 2014 which included: -Communication; -Alzheimer's Disease; and -Caring for Patients with Dementia. On August 24, 2022, at approximately 1:42 p.m., licensed assisted living director/registered nurse (LALD/RN)-A confirmed ULP-D's record lacked documentation of the required eight (8) hours of dementia training. LALD/RN-A stated ULP-D completed the lessons noted above that met all the dementia care training requirements, and ULP-D received dementia care training hours from working with the residents at the facility. The licensee's Dementia Training and Disclosure policy dated August 1, 2021, indicated Direct Care Supervisors must have at least two hours of continuing education annually. Direct Care Staff must have at least eight hours of training within 120 hours of employment start date and two hours continuing education annually. Direct Care Staff must have at least eight hours of training within 160 hours of employment start date and two hours of continuing education annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01770	Continued From page 34	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1) 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: During the entrance conference on August 22, 2022, at approximately 9:00 a.m., licensed assisted living director/registered (LALD/RN)-A confirmed the licensee provided medication management services to include medication setup. R1's diagnoses included spinal stenosis with falls, epilepsy, anxiety, cognitive disorder, dysphagia (difficulty swallowing), and type II diabetes. R1's Client Individual Service/Care Plan date July	01770		

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01770	Continued From page 35 26, 2022, indicated R1 received the following services: medication management, treatment services, assistance with eating, transferring, bathing, grooming, laundry, housekeeping. R1's Client Individuated Medication Management Plan date July 26, 2021, indicated R1 received weekly medication set up. R1's prescriber orders dated October 6, 2021, included three pain medications, three medications to treat shortness of breath, one antifungal, one medication to treat neuropathy, one medication for secretions, cream for dry skin, one eye drop to treat dry eyes, and one eye drop to treat glaucoma. R1's August 2022, Medication Administration Record (MAR) indicated on August 2, 2022, August 9, 2022, and August 16, 2022, LALD/RN-D had setup R1's medications by documenting on the back of R1's MAR date, time indicating a.m. (morning), initials, and documented under the comment section "med set up x 7 days". R1's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, and route of administration. On August 23, 2022, at approximately 9:54 a.m., the surveyor and LALD/RN-A reviewed LALD/RN-A's medication documentation, LALD/RN-A stated she documented the medication setup the same for all residents on the back of the resident's MAR. LALD/RN-A stated she usually completed medication setup on Tuesdays; however, because the surveyor arrived on Monday, LALD/RN-A stayed late	01770		

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01770	Continued From page 36 Monday night and filled all resident's medication planners to be available for the surveyor on Tuesday. LALD/RN-A stated she did not document the medication set up at that time of the setup and was planning on documenting later when the survey was done, and LALD/RN-A had more time. The licensee's Medication Administration System-Dosage Box Set-Up policy dated August 1, 2021, lacked content for documentation requirements for medication set up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of one resident (R1) with bedrails who lacked a comprehensive bedrail assessment to include measurements of the bedrails to determine compliance with Food and Drug Administration (FDA) guidelines for bedrails. This practice resulted in a level three violation (a	02310		

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02310	Continued From page 37 violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate correction order on August 23, 2022 at 3:50 p.m. The findings include: On August 22, 2022, at approximately 9:33 a.m., during entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee had residents who had bedrails on their hospital beds. LALD/RN-A stated all residents who had the need for bedrails had an assessment completed and the bedrails were added to the residents' care plan. The resident and/or resident's representative were provided education on bedrail safety and signed they had received the education, orders were obtained, and the LALD/RN-A had a discussion with medical supply company that provided the hospital bed to make sure the hospital bed with the bedrails was a new bed and meet safety guidelines. On August 22, 2022, at approximately 3:48 p.m., the surveyor observed unlicensed personnel (ULP)-D and ULP-E transfer R1 using a mechanical lift device from his wheelchair into his hospital bed. During the transfer the surveyor observed R1 had bilateral bedrails in the upright position located at the top of the bed, and bedrails in the down position at the lower part of the bed. Both sets of bedrails were securely	02310		

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02310	Continued From page 38 attached to R1's hospital bed. R1's diagnoses included spinal stenosis with falls, epilepsy, anxiety, cognitive disorder, dysphagia (difficulty swallowing), and type II diabetes. R1's Client Individual Service/Care Plan date July 26, 2022, indicated R1 received the following services: medication management, treatment services, assistance with eating, transferring, bathing, grooming, laundry, housekeeping, and required all four bedrails to be in the upright position when R1 was in bed. R1's Comprehensive Nursing Assessment dated August 15, 2022, indicated R1 had limited range of motion, was at risk for falls, and used assistive devices which included: a wheelchair, Hoyer (mechanical lift device), and a shower chair. R1's assessment lacked the use of bedrails. On August 23, 2022, at approximately 1:17 p.m., LALD/RN-A confirmed she does not complete bedrail assessments or bedrail measurements to determine if the bedrails met FDA's standards. LALD/RN-A stated she communicates with the medical supply company when ordering the hospital bed with bedrails to make sure the hospital bed was new and met all safety guidelines. LALD/RN-A stated she does not complete ongoing bedrail assessments unless there was a change in the resident's condition or if she was informed the resident was not using the bedrail appropriately. LALD/RN-A confirmed R1's record lacked evidence of bedrail measurements and a comprehensive bedrail assessment. On August 23, 2022, at approximately 2:53 p.m., ULP-F stated R1's care plan directed staff to put	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32149	A. BUILDING: _____ B. WING _____	08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFESTONE HEALTH CARE INC	319 7TH STREET PROCTOR, MN 55810

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02310	Continued From page 39	02310		

all four bedrails in the up position when R1 was in bed to prevent R1 from falling out of bed. ULP-F stated she was not aware of R1 ever falling out of bed; however, R1 moved around a lot.

On August 23, 2022, at approximately 3:00 p.m., ULP-D stated R1's care plan indicated when R1 was in bed, all four bedrails were to be in the upright position. ULP-D stated she was unaware of any time R1 had ever fallen out of bed.

The licensee's Assessing the Safety of Side Rails policy dated August 1, 2021, indicated when notified that a client had side rails, the RN would assess and evaluate what the client's needs are and assess to determine if the client can safely utilize the siderail/equipment and determine whether the side rail/equipment meets the FDA standards for side rails. The RN would evaluate whether the side rail appeared to be safe for the resident. The RN would educate the client, the client's representative and/or family members about the risks related to side rails, and if the client's side rail does not appear to meet FDA standards, the RN would recommend to the client, the client's representative, the client's involved family members that the side rail be removed and would recommend alternative options to reduce the risk of a fall out of bed. The RN would document those conversations and recommendations.

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than 4 and 3/4 inches.

The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When

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02310	Continued From page 40 bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No futher information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by review of plan of correction by evaluation supervisor on August 25, 2022, however, noncompliance remains at a scope and severity of level three, widespread (I). TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=F	144G.91 Subd. 4 Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications	02320		

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02320	Continued From page 41 were administered in accordance with accepted standards for one of eight residents (R1) whose medications were set up by unlicensed personnel ahead of time for later administration. This had potential to affect all eight (8) residents of 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: During entrance conference on August 22, 2022, at approximately 9:33 a.m., licensed assisted living director/registered nurse (LALD/RN)-A confirmed all residents received medication set up by the licensee. R1's diagnoses included spinal stenosis with falls, epilepsy, anxiety, cognitive disorder, dysphagia (difficulty swallowing), and type II diabetes. R1's Client Individual Service/Care Plan date July 26, 2022, indicated R1 received the following services to include medication management. R1's annual prescriber orders dated October 6, 2021, included the following medications: -Refresh Tears 0.5-0.9% one drop in each eye every four hours for dry eyes; -Combivent Respimat inhaler one puff every four hours when nebulizer unavailable for shortness of breath; -albuterol HFA inhaler take two puffs every hour	02320		

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02320	Continued From page 42	02320		

as needed for shortness of breath;
-albuterol neb 0.083% one vial four times a day for shortness of breath;
-hydromophon 2 milligrams (mg) one tablet by mouth four times a day for pain;
-hydromophon 2 mg half tablet every four hours as needed for pain;
-hyoscyamine 0.125 mg one tablet underneath the tongue every four hours as needed for secretions;
-Latanoprost 0.005% solution one drop in each eye at bedtime for glaucoma;
-acetaminophen 325 mg three tablets by mouth three times a day for pain or fever;
-gabapentin 600 mg one tablet by mouth three times a day for neuropathy;
-lorazepam 0.5 mg one tablet three times daily for anxiety and seizures;
-lorazepam 0.5 mg one tablet every two hours as needed for anxiety and seizures;
-clotrimazole cream 1% apply to affected and surrounding areas of skin, face twice daily for antifungal;
-protective barrier ointment apply topically to skin and buttocks as needed for prevention of skin breakdown; and
-nitroglycerin 0.4 mg one tablet underneath the tongue every five minutes times three doses as needed for chest pain.

On August 22, 2022, at approximately 1:00 p.m., the surveyor was going to observe unlicensed personnel (ULP)-B prepare and administer resident's afternoon scheduled medications; however, the residents' medications had already been set up earlier that morning for each resident to be administered during the morning shift. In the medication room off the kitchen, the surveyor observed a table marked with masking tape of individual resident initials. Next to the masking

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02320	Continued From page 43	02320		

tape with resident's initials were clear plastic condiment like containers with lids that contained resident medications. The plastic lids were labeled in black permanent marker the following information: resident initials, number of pills in the container, date and time of the medications were to be administered. ULP-B stated at the beginning of each shift, staff pre-set up all residents' medications scheduled to be administered during their shift. ULP-B stated staff took the resident's prefilled medication dosage boxes that had been previously set up by LALD/RN-A, set up those medications in clear plastic medication cups, labeled the lids with the content noted above and administered at scheduled times. The surveyor observed ULP-B administer R1's medications that were pre-set up by ULP-B earlier that day.

On August 22, 2022, at approximately 3:20 p.m., the surveyor observed ULP-D direct ULP-E in setting up resident medications from medication dosage boxes into clear plastic condiment-like containers to later administer using the same procedure noted above.

R1's August 2022 Medication Administration Record (MAR) lacked description or other identification of each medication set up by the LALD/RN, however, did list the number of pills to that were to be administered for each medication administration pass.

R1's August 2022 MAR, indicated on August 22, 2022, R1 received the following medications pre-set up by ULP-E at 4:00 p.m.:
-Refresh Tears 0.5-0.9% one drop in each eye; and
-hydromorphon 2 milligrams (mg) one tablet by mouth.

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02320	Continued From page 44 R1's August 2022 MAR indicated on August 22, 2022, R1 received the following medications pre-set up by ULP-E at 8:00 p.m.: -Latanoprost 0.005% solution one drop in each eye; -Refresh Tears one drop in both eyes; -Hydromorphone 2 mg one tablet by mouth; -acetaminophen 325 mg two tablets by mouth; -gabapentin 600 mg one tablet by mouth; -lorazepam 0.5 mg one tablet by mouth; and -quetiapine 25 mg one tablet by mouth. On August 23, 2022, at approximately 9:54 a.m., LALD/RN-A confirmed resident medications came from the pharmacy in bubble packs (a transparent molded piece of plastic often sealed to a sheet of cardboard, used to package tablets) and LALD/RN-A took those medications and set up them in a medication dosage box every Tuesday. ULP's were trained to take the medications from the medication dosage boxes and set them up in individual medication containers to administer at a later time. LALD/RN-A stated since she started that practice, it had reduced medication errors. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02380 SS=C	144G.91 Subd. 10 Individual autonomy Residents have the right to individual autonomy, initiative, and independence in making life choices, including establishing a daily schedule and choosing with whom to interact.	02380		

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02380	Continued From page 45 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure residents had right to individual autonomy, initiative, and independence in making life choices, including having access to television or music in the common area without restricted hours. This had the potential to affect all eight (8) 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 August 22, 2022, at approximately 9:00 a.m., during the entrance conference, the surveyor requested a copy of the facility's assisted living contract. The assisted living contract provided included restricted hours the clients could watch television or listen to music in the common areas. Page 7, section O. under IX., indicated clients were expected to be respectful in the common area; and out of respect for other clients, television and/or music in the common areas are turn off by 10 p.m., and back on at 5 a.m., daily. On August 23, 2022, at approximately 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A confirmed the same assisted living contract was used for all residents at the facility.	02380		

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02380	Continued From page 46 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02380		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice to visitors was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity potentially, affecting all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 22, 2022, at approximately 8:49 a.m.,	03090		

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03090	Continued From page 47 upon entrance of the facility, the surveyor observed signage posted at the main entrance that indicated, "Premises Protected By 24 Hour Video Surveillance". On August 22, 2022, at approximately 12:12 p.m., during the facility tour with licensed assisted living director/registered nurse (LALD/RN)-A and unlicensed personnel (ULP)-D, LALD/RN-A confirmed there were video cameras throughout areas of the facility. LALD/RN-A stated she was not aware the surveillance sign required the exact statutory language because the licensee did not have any electronic audio recording devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *08/22/22*
Time: 10:30:00
Report: 1006221102

Food and Beverage Establishment Inspection Report

Location:
Lifestone Health Care Inc
319 7th Street
Proctor, MN55810
St. Louis County, 69

Establishment Info:
ID #: 0038812
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2184817306
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

FOODS IN THE ONE HOMESTYLE REFRIGERATOR WERE ABOVE 41F(JAM AND MILK 45F, EGG SALAD 46F). FRIDGE WAS ADJUSTED FROM "2" TO "5". EGG SALAD WAS DISCARDED AND OTHER TCS FOODS WERE MOVED TO THE OTHER REFRIGERATOR UNTIL THE TEMP COMES DOWN.

Corrected on Site

3-800 Highly Susceptible Populations

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

4626.0447B(2)- SCRAMBLED EGGS ARE ON THE MENU AND STAFF MENTIONED THEY WILL MAKE BREAKFAST CASSEROLE, BOTH MADE WITH REGULAR SHELL EGGS. DISCUSSED WHEN TO USE PASTEURIZED EGGS AND PROVIDED FACT SHEET. SEE COMMENTS.

Comply By: 08/22/22

2-100 Supervision

2-102.12AMN

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

THERE IS NO CERTIFIED FOOD PROTECTION MANAGER. HAVE AT LEAST ONE PERSON RECEIVE THE STATE CERTIFIED FOOD PROTECTION MANAGERS CERTIFICATE.

INFORMATION ON CFPM CERTIFICATE EMAILED WITH REPORT.
Comply By: 10/22/22

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

THERE IS NO CERTIFIED FOOD PROTECTION MANAGER AT THE FACILITY. ONCE AT LEAST ONE PERSON RECEIVES THE CERTIFICATE POST THE CERTIFICATE SOMEWHERE VISIBLE IN THE ESTABLISHMENT.
Comply By: 10/22/22

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

THERE WAS A HOT DISH LEFTOVER FROM THE PREVIOUS DAY IN THE REFRIGERATOR. DISCUSSED THAT FOODS PREPARED IN THE ESTABLISHMENT'S HOME STYLE KITCHEN ARE TO BE HELD FOR SAME DAY SERVICE ONLY. HOT DISH WAS DISCARDED.
Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANITIZER SPRAY
Violation Issued: No

Hot Water: = at 160F Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Homestyle Refrigerator/fre
Temperature: 45 Degrees Fahrenheit - Location: RASPBERRY JAM
Violation Issued: Yes

Process/Item: Homestyle Refrigerator/fre
Temperature: 46 Degrees Fahrenheit - Location: EGG SALAD
Violation Issued: Yes

Process/Item: Homestyle Refrigerator/fre
Temperature: 45 Degrees Fahrenheit - Location: MILK
Violation Issued: Yes

Process/Item: Homestyle Refrigerator/fre
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Homestyle Refrigerator/fre
Temperature: 38 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Homestyle Refrigerator/fre
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Cooking
Temperature: 197 Degrees Fahrenheit - Location: BEEF (BEEF STEW)
Violation Issued: No

Process/Item: Cooking
Temperature: 180 Degrees Fahrenheit - Location: BEEF (BEEF STEW)
Violation Issued: No

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

COMMENTS:

INSPECTION ACCOMPANIED BY PRESIDENT, CHIAMAKA ENEMUOH.

EGGS:
4626.0447 FOOD SERVED TO A HIGHLY SUSCEPTIBLE POPULATION. 3-801.11
B. Pasteurized eggs or egg products must be substituted for raw eggs in the preparation of:

(1) foods such as Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages;P1 and

(2) except as specified in item F, recipes in which more than 1 egg is broken and the eggs are combined.P1

F. Item B, subitem (2), does not apply if:

(1) the raw eggs are combined immediately before cooking for one consumer's serving at a single meal, cooked as specified in part 4626.0340, item A, subitem (1), and served immediately, such as an omelet, souffle, or scrambled eggs;

(2) the raw eggs are combined as an ingredient immediately before baking and the eggs are thoroughly cooked to a ready-to-eat form, such as a cake, muffin, or bread; or

(3) the preparation of the food is conducted under a HACCP plan that:
(a) identifies the food to be prepared;
(b) prohibits contacting ready-to-eat food with bare hands;
(c) includes specifications and practices that ensure:
i. Salmonella Enteritidis growth is controlled before and after cooking; and
ii. Salmonella Enteritidis is destroyed by cooking the eggs according to the temperature and time specified in part 4626.0340, item A, subitem (2);
(d) contains the information in part 4626.1735, item D, including procedures that:
i. control cross-contamination of ready-to-eat food with raw eggs; and
ii. delineate cleaning and sanitization procedures for food-contact surfaces; and

(e) describes the training program that ensures that the food employee responsible for the preparation of the food understands the procedures to be used.

DISCUSSED WITH THE PRESIDENT EITHER SWITCHING THE BREAKFAST OPTION ON THE DAY THAT LISTED SCRAMBLED EGGS OR GETTING PASTEURIZED EGGS TO BE ABLE TO OFFER SCRAMBLED EGGS THAT DAY.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH HEPATITIS A., SHIGA TOXIN-PRODUCING E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS, OR F ANY RESIDENTS COMPLAIN OF A SUSPECTED FOODBORNE ILLNESS.

OBSERVED GOOD HAND WASHING AND EXCLUSION OF BARE HAND CONTACT WITH READY TO EAT FOODS DURING THE INSPECTION. DISCUSSED THE IMPORTANCE OF HAND WASHING WITH STAFF AND EXCLUDING BARE HAND CONTACT WITH ALL READY TO EAT FOODS BY USING GLOVES, TONGS, DELI TISSUE, ETC.

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 1006221102 of 08/22/22.

Certified Food Protection Manager: none

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Chiamaka Enemuoh
President

Signed: _____
Callie Harrison

218-302-6173
callie.harrison@state.mn.us

Report #: 1006221102

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	3	Date	08/22/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

Lifestone Health Care Inc	Address: 319 7th Street	City/State: Proctor, MN	Zip Code: 55810	Telephone: 2184817306

License/Permit #: 0038812	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

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

Compliance Status	COS	R
Surpervision		
1 (IN) OUT — PIC knowledgeable; duties & oversight		
2 IN (OUT) N/A — Certified food protection manager, duties		
Employee Health		
3 (IN) OUT — Mgmt/Staff;knowledge,responsibilities&reporting		
4 (IN) OUT — Proper use of reporting, restriction & exclusion		
5 (IN) OUT — Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices		
6 (IN) OUT N/O — Proper eating, tasting, drinking, or tobacco use		
7 (IN) OUT N/O — No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands		
8 (IN) OUT N/O — Hands clean & properly washed		
9 (IN) OUT N/A N/O — No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 (IN) OUT — Adequate handwashing sinks supplied/accessible		
Approved Source		
11 (IN) OUT — Food obtained from approved source		
12 IN OUT N/A (N/O) — Food received at proper temperature		
13 (IN) OUT — Food in good condition, safe, & unadulterated		
14 IN OUT (N/A) N/O — Required records available; shellstock tags, parasite destruction		
Protection from Contamination		
15 (IN) OUT N/A N/O — Food separated and protected		
16 (IN) OUT N/A — Food contact surfaces: cleaned & sanitized		
17 (IN) OUT — Proper disposition of returned, previously served, reconditioned, & unsafe food		

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

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

GOOD RETAIL PRACTICES

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

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

			COS	R
Safe Food and Water				
30		IN OUT (N/A) — Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32		IN OUT (N/A) — Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34		IN OUT (N/A) N/O — Plant food properly cooked for hot holding		
35		IN OUT N/A (N/O) — Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used	X	
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 08/24/22

Inspector (Signature) Callie Hanson