Electronically Delivered

May 1, 2023

Licensee
Northern Oak Place
1005 Paul Parkway Northeast
Blaine, MN 55434

RE: Project Number(s) SL30625015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 6, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30625	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN OAK PLACE	1005 PAUL PARKWAY NE BLAINE, MN 55434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30625015 On April 4, 2023 through April 6, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 16 active residents; all receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 5, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United	0 485		

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0 485	Continued From page 2 States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; 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 require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. 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 the residents). The findings include: The licensee's Assisted Living Contract, page 1, indicated: Definitions -In this Agreement, the term "Monthly Fee	0 485		

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0 485	Continued From page 3 Schedule" means the fees that the Resident pays for rent, board, and services set forth in Section 6 of this Agreement and on Addendum "A", the Schedule of Monthly Rent, Board, and Service Fees, and does not include any fees or charges associated with services provided to the Resident pursuant to the Resident Individualized Service Plan, A la Carte services, or any other services for which the Resident may contract. The licensee's Assisted Living Contract, page 4, section 6. Programs and Services indicated: Assisted Living Program: Rent: a. Apartment unit, with lawn care, snow removal, building insurance, payment of property taxes, and management services; b. Security door system c. All utilities including basic dish TV, except telephone service d. Garbage and trash removal e. All inside and outside building maintenance, including window washing, changing furnace filters, maintaining and cleaning common areas. Board: f. 1 meal per day, served in the Community dining rooms g. Use of common areas h. 24 Hour home health staff i. Availability a personalized service coordination j. Completing the Comprehensive Assessment, and developing the Individualized Service Plan with an interdisciplinary team k. Nurse availability for supervision, delegation, and charting l. Monthly help monitoring of vitals m. Scheduled Transportation Services: n. Emergency Call System	0 485		

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0 485	Continued From page 4 o. Personal laundry, total of 2 loads weekly and weekly change of Resident linens p. 2 meals per day, served in the Community dining room q. Activities and exercise program r. Weekly housekeeping, at 30 minutes per individual unit, and all common areas s. Daily resident checks t. Personal transportation. The licensee's Rate Agreement-Memory Care indicated services included in base rent included 3 daily meals and daily refreshments and snacks. On April 6, 2023, at 11:25 a.m., licensed assisted living director (LALD)-B stated the contract included the meals into the base rent and there was not an option to opt out of meals and was unaware that an option for residents to opt out of meals was a requirement. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for	0 580		

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0 580	Continued From page 5 two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current 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 the residents). The findings include: On April 4, 2023, at 2:00 p.m., the surveyor reviewed the licensee's quality management plan binder. The documents in the binder consisted of the quality management policy and procedures but did not include any documentation of meeting minutes or notes. On April 6, 2023, at 11:40 a.m., licensed assisted living director (LALD)-B stated she does not know why they do not have documentation of their quality management meetings. LALD-B stated she was aware of the statute requirements, but it was just one of the things that slipped through the cracks. LALD-B further stated they have staff meetings where they discuss quality items but have no documentation of them.	0 580		

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0 580	Continued From page 6 The licensee's Quality Management Program policy dated July 20, 2022, indicated the committee maintains written accounts of meetings conducted and recommendations and actions taken by the committee. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680		

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0 680	Continued From page 7 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated Emergency Preparedness Plan (EPP) failed to include the following required content: -current, all-hazards approach facility assessment -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations -procedure for tracking staff and residents -development of all policies/procedures, based on assessment; and additional policies for -handling medical documents -handling and use of volunteers -role of facility under a waiver declared by the Secretary -development of a communication plan, including primary and alternate means for communication including names/contact information for staff, entities providing services under agreement, residents' physicians, other facilities, volunteers	0 680		

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0 680	Continued From page 8 -communication plan must include primary and alternate means of communicating with facility staff and Federal, State, tribal, and local emergency management services -methods for sharing information -EP training and testing program -EP training program for staff (including documentation of training provided); and -annual EP testing requirements Additionally, the licensee's EPP lacked evidence it was updated for reviewed annually, as required. On April 6, 2023, at 10:55 a.m., licensed assisted living director (LALD)-B stated there were Appendix Z requirements missing from their emergency plan. The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated [the facility] will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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	0 800		

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0 800	Continued From page 9 residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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). Findings include: On April 5, 2023, between 10:30 a.m. and 11:40 a.m., survey staff toured the facility with the building engineer (BE)-F. During the facility tour, survey staff observed the following: 1. The electromagnetic door holder was broken for one of the fire doors. The fire door was propped open with a wedge during the facility tour. Propping open a fire door would prevent the required operation and closing feature of this door. 2. Two doors leading to the enclosed patio area had exit signs posted over them, but the snow and ice had not been cleared for a path, which	0 800		

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0 800	Continued From page 10 obstructed the path of egress. All paths of egress must be maintained and clear of obstructions to allow residents, staff, and visitors to exit the building in a safe and efficient manner in the event of an emergency. 3. The inspection tag was dated 2017 for the reduced pressure (RPZ) device in the Fire Alarm Panel Room. The owner of the backflow prevention device is responsible for making sure the backflow device is tested annually. 4. Several electrical wall outlets in resident common areas were not provided with covers. Electrical outlets that are not properly covered could expose residents to electrical wiring. 5. The window blind was broken in resident room 13. These deficient conditions were visually verified by BE-F accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (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	0 810		

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0 810	Continued From page 11 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop fire safety and evacuation plans with the required elements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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). Findings include:	0 810		

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0 810	Continued From page 12 On April 5, 2023, at approximately 11:40 a.m., records were provided for review. Records were reviewed by survey staff on April 5, 2023, between 11:40 a.m. and 12:25 p.m. Record review indicated that the fire safety and evacuation plans were not developed for the facility location and did not include the following required elements: 1. Employee actions to be taken in the event of a fire or similar emergency. 2. Fire Protection procedures necessary for residents. On April 5, 2023, at approximately 12:30 p.m., the licensed assisted living director (LALD)-B and the building engineer (BE)-F verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living	0 980		

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0 980	Continued From page 13 contract's arbitration provision did not preclude, limit, or delay the ability of a resident from taking civil action. This practice resulted in a level one violation and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The assisted living contract provided included an arbitration section which precluded, limited, or delayed the ability of a resident from taking civil action. Page 15, section 35. contained a section titled Mandatory and Binding Arbitration indicating "any dispute, claim or controversy...shall be determined by binding arbitration in Rochester, MN before three (3) arbitrators. The arbitration shall be administered by JAMS pursuant to its comprehensive arbitration rules and procedures...". On April 6, 2023, at 11:25 a.m., licensed assisted living director (LALD)-B stated the contract included language that limited the choice of a venue provision and all of the contracts were the same. LALD-B stated the contracts were done by corporate and she was not familiar with the statute regarding arbitration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 980		
01290 SS=D	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 14 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for one of two employees (unlicensed personnel (ULP)-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 3, 2023, at 9:15 a.m., the surveyor observed ULP-G provide medication	01290		

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01290	Continued From page 15 administration to residents. ULP-G began employment with the licensee December 13, 2022, to provide assisted living services. ULP-G's employee record contained a background study dated December 20, 2022, associated to the corporate HFID number 30479. ULP-G's employee record lacked evidence the licensee submitted a background study for ULP-G under the current HFID number 30625. On April 6, 2023, at 11:40 a.m., licensed assisted living director (LALD)-B stated she was unaware that the employees were not associated with the facility's HFID and was under the impression that if employees were associated with one of the other managing companies HFIDs this was sufficient. The licensee's 5.04 Background Checks policy dated February 1, 2022, indicated the licensee will perform background checks on all individuals they plan to employ, contract with, or offer volunteer opportunities to if they will work for any period of time in the facility with contact with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following:	01370		

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01370	Continued From page 16 (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01370		

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01370	Continued From page 17	01370		

review, the licensee failed to ensure required training was completed for three of three employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

ULP-G
ULP-G was hired on December 13, 2022, and was observed providing direct care services to residents on April 4 through April 6, 2023.

ULP-G's employee record lacked documentation of the following required training to be completed by ULP:
-documentation requirements for all services provided;
-reports of changes in the resident's condition to the supervisor designated by the facility;
-training on the prevention of falls;
-communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and
-understanding appropriate boundaries between staff and residents and the resident's family.

ULP-H
ULP-H was hired on April 29, 2022, and was observed providing direct care services to residents on April 5, 2023 and April 6, 2023.

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01370	Continued From page 18 ULP-H's employee record lacked documentation of the following required training to be completed by ULP: -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the facility -training on the prevention of falls -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and -understanding appropriate boundaries between staff and residents and the resident's family. ULP-I ULP-I was hired on April 29, 2022, to provide direct care services to residents. ULP-I's employee record lacked documentation of the following required training to be completed by ULP: -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the facility -training on the prevention of falls -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; and -understanding appropriate boundaries between staff and residents and the resident's family. On April 5, 2023, at 9:15 a.m., ULP-G stated he had completed his competency training with clinical nurse supervisor (CNS)-C. On April 6, 2023, at 10:20 a.m., CNS-C stated	01370		

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01370	Continued From page 19 due to not being able to access their electronic education system, none of the current unlicensed staff would have all the required training completed. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated: Training and competency evaluations for all ULP's will include: -Documentation requirements for all services provided -Reports of changes in the resident's condition to the supervisor designated by the facility -Training on the prevention of falls -Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family -Awareness of confidentiality and privacy -Understanding appropriate boundaries between staff and residents and the resident's family No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	01380		

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01380	Continued From page 20 appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for three of three employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-G ULP-G was hired on December 13, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On April 5, 2023, at 9:15 a.m., the surveyor observed ULP-G administer R3 and R4's morning medications. ULP-G's employee record lacked evidence ULP-G had received the following training and	01380		

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01380	Continued From page 21	01380		

competency:
-observing, reporting, and documenting resident status;
-basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and
- recognizing physical, emotional, cognitive, and developmental needs of the resident.

ULP-H
ULP-H was hired on April 29, 2022, to provide direct care services under the licensee's assisted living with dementia care license.

On April 5, 2023, throughout the day the surveyor observed ULP-H provide direct care services to several residents.

ULP-H's employee record lacked evidence ULP-H had received the following training and competency:
-observing, reporting, and documenting resident status;
-basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and
-recognizing physical, emotional, cognitive, and developmental needs of the resident.

ULP-I
ULP-I was hired on April 29, 2022, to provide direct care services under the licensee's assisted living with dementia care license.

ULP-I's employee record lacked evidence ULP-I had received the following training and competency:
-observing, reporting, and documenting resident

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01380	Continued From page 22 status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the resident. On April 6, 2023, at 10:20 a.m., clinical nurse supervisor (CNS)-C stated some of the required training topics were missed due to the electronic training system not working and the staff not having all the education completed. CNS-C stated this was the case for all the current ULP employees. The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations for all unlicensed personnel include: -observing, reporting, and documenting resident status -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel -recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	01470		

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01470	Continued From page 23 (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (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	01470		

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01470	Continued From page 24 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three unlicensed personnel (ULP-G, ULP-H, ULP-I) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-G ULP-G was hired on December 13, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On April 5, 2023, at 9:15 a.m., the surveyor observed ULP-G administer R3 and R4's morning	01470		

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01470	Continued From page 25 medications. ULP-G's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter - an introduction and review of the facilities policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - principles of person-centered planning and service delivery - handling of resident /client's complaints, reporting of complaints, where to report complaints; and - consumer advocacy services. ULP-H ULP-H was hired on April 29, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On April 5, 2023, throughout the day the surveyor observed ULP-H provide direct care services to several residents. ULP-H's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter - an introduction and review of the facilities	01470		

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01470	Continued From page 26 policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - principles of person-centered planning and service delivery - handling of resident /client's complaints, reporting of complaints, where to report complaints; and - consumer advocacy services. ULP-I ULP-I was hired on April 29, 2022, to provide direct care services under the licensee's assisted living with dementia care license. ULP-I's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter - an introduction and review of the facilities policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - principles of person-centered planning and service delivery - handling of resident /client's complaints, reporting of complaints, where to report complaints; and - consumer advocacy services.	01470		

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01470	Continued From page 27 On April 6, 2023, at 10:20 a.m. clinical nurse supervisor (CNS)-C stated all the required orientation topics had not been completed. CNS-C stated all current staff would be missing the required orientation training. The licensee's policy 5.01, Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must contain the following topics: -An overview of the appropriate assisted living statutes and rules -An introduction and review of the facilities policies and procedures related to the provision of assisted living services by the individual staff person handling of emergencies and use of emergency services -Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -The assisted living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -Handling of residents' complaints reporting of complaints and where to report complaints including information on the Office of Health Facility Complaints -Consumer advocacy services. No further information provided. TIME PERIOD FOR CORRECTION:	01470		

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	30625	A. BUILDING: _____ B. WING _____	04/06/2023

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01470	Continued From page 28 Twenty-One (21) days	01470		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-G, ULP-H, ULP-I) received the required amount of dementia care training in the required time frame. 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	01540		

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01540	Continued From page 29 the residents). The findings include: ULP-G ULP-G was hired on December 13, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On April 5, 2023, at 9:15 a.m., the surveyor observed ULP-G administer R3 and R4's morning medications. ULP-G's employee record did not indicate a total of eight hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-G's employee record indicated the employee had completed 0 hours of dementia training. ULP-H ULP-H was hired on April 29, 2022, to provide direct care services under the licensee's assisted living with dementia care license. On April 5, 2023, throughout the day the surveyor observed ULP-H provide direct care services to several residents. ULP-H's employee record did not indicate a total of eight hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-H's employee record indicated the employee had completed 5.5 hours of dementia training. ULP-I ULP-I was hired on April 29, 2022, to provide direct care services under the licensee's assisted living with dementia care license.	01540		

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01540	Continued From page 30 ULP-I's employee record did not indicate a total of eight hours of the required dementia training was completed within 80 hours of the employee's start date. ULP-I's employee record indicated the employee had completed 0 hours of dementia training. On April 5, 2023, at 12:30 p.m., clinical nurse supervisor (CNS)-C stated ULP-G had not completed any electronic computer training including the dementia care training because they had not been able to get access to the electronic computer system. On April 5, 2023, at 12:30 p.m., licensed assisted living director (LALD)-B stated they had been having an issue with electronic computer training since December. On April 5, 2023, at 2:40 p.m., CNS-C stated only one of the additional employee files requested had any dementia care training, but it was not the full 8 hours. CNS-C stated all the current unlicensed staff have not completed their dementia care training. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated all direct care employees would complete eight (8) hours of initial dementia care training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		

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01640	Continued From page 31	01640		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was revised based on change of service for one of two residents (R3) and failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the facility to document agreement on the services to be provided for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 32	01640		

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

The findings include:

REVISED SERVICE PLAN
R3
R3's record lacked documentation the service plan was revised after a service was removed.

R3's diagnoses included dementia, history of traumatic fracture, essential hypertension (high blood pressure), weakness, and history of falling.

R3's unsigned and undated service plan, indicated R3 received assistance with CPAP (continuous positive airway pressure) management, grooming, dressing, showers, transfers, toileting, meals, housekeeping, and laundry.

R3's Rate Agreement-Memory Care, signed and dated January 18, 2023, indicated R3 would receive assistance with basic medication management, stand by assistance with dressing and bath, transfers, toileting reminders, meals, housekeeping, and laundry. The rate agreement indicated the only additional clinical offering was behavioral staff interventions 1-5 occurrences a month.

On April 5, 2023, at 9:45 a.m., unlicensed personnel (ULP)-G stated R3 had not used a CPAP machine since he had started working here.

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01640	Continued From page 33 On April 6, 2023, at 10:20 a.m., clinical nurse supervisor (CNS)-C stated R3 does not use a CPAP anymore but had not removed it from his service plan. AUTHENTICATION R2 R2 was admitted to the licensee for assisted living services on June 1, 2022. R2's diagnoses included unspecified dementia. R2's unsigned and undated service plan indicated R2 required assistance with showers, grooming, dressing, toileting, meals, and medication management. R3 R3 was admitted to the licensee for assisted living services on June 1, 2022. R3's diagnoses included dementia, history of traumatic fracture, essential hypertension (high blood pressure), weakness, and history of falling. R3's unsigned and undated service plan, indicated R3 received assistance with CPAP (continuous positive airway pressure) management, grooming, dressing, showers, transfers, toileting, meals, housekeeping, and laundry. R2 and R3's service plans lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. On April 6, 2023, CNS-C stated the service plans	01640		

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01640	Continued From page 34 were all missing signatures. The licensee's Service Plan policy dated August 1, 2021, indicated a service plan and any revisions shall include a signature or other authentication by [facility] and by the resident or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650		

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01650	Continued From page 35 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident service plans included all the required content for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2 R2's diagnoses included unspecified dementia. R2's undated and unsigned service plan indicated R2 required assistance with showers, grooming, dressing, toileting, meals, and medication management. R2's undated and unsigned service plan lacked the following: -the frequency of each service according to the resident's current assessment and resident preferences -the schedule and methods of monitoring	01650		

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01650	Continued From page 36 assessments of the resident -information and a method to contact the facility R3 R3's diagnoses included dementia, history of traumatic fracture, essential hypertension (high blood pressure), weakness, and history of falling. R3's undated and unsigned service plan, indicated R3 received assistance with CPAP (continuous positive airway pressure) management, grooming, dressing, showers, transfers, toileting, meals, housekeeping, and laundry. R3's undated and unsigned service plan lacked the following: -the frequency of each service according to the resident's current assessment and resident preferences -the schedule and methods of monitoring assessments of the resident -information and a method to contact the facility On April 6. 2023, at 10:20 a.m., the clinical nurse supervisor (CNS)-C stated the older service plans were missing the frequency of services, assessment schedule or method, and information to contact the facility regarding the contingency plan. CNS-C stated most of the resident service plans would be missing this required information. The licensee's Service Plan policy dated August 1, 2021, indicated a service plan will include: -the frequency of each service to be provided based on the most recent assessment and resident preferences -a schedule and method for the next planned assessment or monitoring -information regarding how the resident can	01650		

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01650	Continued From page 37 contact [facility] No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration,	01730		

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01730	Continued From page 38 verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication plan to include documentation of specific resident instructions relating to the administration of medications for one of three residents (R4). 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: During the entrance conference on April 4, 2023, at 10:30 a.m., clinical nurse supervisor (CNS)-A stated the whole building was a secure unit and the licensee provided medication management services to all the residents. On April 5, 2023, at 9:15 a.m., the surveyor	01730		

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01730	Continued From page 39 observed unlicensed personnel (ULP)-G crush medications and place the medications in applesauce for R4. ULP-G brought the crushed medications in applesauce to the kitchen area and administered them to R4. R4's diagnoses included dementia. R4's MN Medication/Treatment/Therapy Assessment and Plan, dated March 14, 2023, noted R4 had advanced dementia and needs full assistance with medications. However, it lacked specific instructions relating to the administration of medications to include crushing the medications or placing them in food. R4's signed prescriber orders dated April 20, 2022, included four different scheduled medications and one as needed medication but did not indicate to crush the medications or place them in food. R4's April 2023 Medication Administration Record (MAR) listed medications as prescribed, times to administer, and area for staff initials on each date but did not indicate specific instructions to crush medications or place them in food. On April 5, 2023, at 9:15 a.m., ULP-G stated there were no instructions in R4's MAR to crush her medications or give them in applesauce but all staff knew R4 cannot swallow them whole, so you must crush them. On April 6, 2023, at 10:20 a.m., CNS-C stated R4's MAR was missing specific instructions for medications to be crushed or placed in applesauce and will contact the provider to get orders for these instructions and add the instructions to the MAR.	01730		

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01730	Continued From page 40 The licensee's 7.15 Medication and Treatment - Administration and Delegation policy dated August 1, 2021, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel the licensee will ensure that the registered nurse has: -specified, in writing, specific instructions for each resident and documented those instructions in the residence records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the	02040		

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02040	Continued From page 41 ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On April 5, 2023, at approximately 11:40 a.m., records were provided for review. At that time, survey staff requested a hazard vulnerability or safety risk assessment for the physical environment from the licensed assisted living director (LALD)-B. Records were reviewed by survey staff on April 5, 2023, between 11:40 a.m. and 12:25 p.m. Documentation to support that the licensee had performed a safety risk assessment or hazard vulnerability assessment with mitigation factors on and around the property for the physical environment was not provided. On April 5, 2023, at approximately 12:30 p.m., the licensed assisted living director (LALD)-B explained that they had not been able to locate the assessment and verified this deficient condition. On April 5, 2023, at 5:13 p.m., the (LALD)-B emailed survey staff a Hazard Vulnerability Mitigation Plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN OAK PLACE	1005 PAUL PARKWAY NE BLAINE, MN 55434

(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
02170	Continued From page 42	02170		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30625	A. BUILDING: _____ B. WING _____	04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHERN OAK PLACE	1005 PAUL PARKWAY NE BLAINE, MN 55434

(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
02170	Continued From page 43 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for two of two residents (R2, R3) who resided in the assisted living with dementia care 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 the residents). The findings include: The licensee held an assisted living with dementia care license. The facility was licensed for a capacity of 25 residents and had a current census of 14 residents. R2's diagnoses included unspecified dementia. R3's diagnoses included dementia, history of traumatic fracture, essential hypertension (high blood pressure), weakness, and history of falling. R2 and R3's records lacked all the required content of the activity's evaluation. In addition, the records lacked an individualized activity plan based on the activity evaluation that reflected the residents' activity preference and needs.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30625	A. BUILDING: _____ B. WING _____	04/06/2023

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02170	Continued From page 44 On April 6, 2023, at 11:50 a.m., licensed assisted living director (LALD)-B stated she was not aware of the statute regarding activity plans. The licensee's ALDC Life Enrichment Programs, Activities & Outdoor Space policy dated August 1, 2021, indicated each resident must be evaluated for activities according to the licensing rules of the facility, and the evaluation must address the following: -past and current interests -current abilities and skills -emotional and social needs and patterns -physical abilities and limitations -adaptations necessary for the resident to participate -identification of activities for behavioral interventions It also noted an individualized activity plan must be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/05/23*
Time: 13:00:00
Report: 1025231081

Food and Beverage Establishment Inspection Report

Location:
Northern Oak Place
1005 Paul Parkway NE
Blaine, MN55434
Anoka County, 02

Establishment Info:
ID #: 0041175
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
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.

4-500 Equipment Maintenance and Operation

4-501.114C1 ** Priority 1 **

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

Dish machine failed to test for chlorine (0 PPM); discontinue use of dish machine for sanitizing until serviced and verified; see comments (4/5)

Comply By: 04/05/23

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Provide a thin-probe type food thermometer for the kitchen (bi-metal dial can be used for roasts and thick items).

Comply By: 04/12/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Provide a test kit for the quat ammonia sanitizing solution, and any chlorine, if it is to be used to sanitize in the dish machine, and peroxide if the chemical is used for sanitize food contact surfaces (dispenser in utility room).

Comply By: 04/07/23

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Unable to verify stove/oven range unit, cooking appliances (griddle, rice cooker) meet the requirements for cooking equipment. Reported facility does cook TCS foods for multiple day service. Provide a menu or equipment complying with the above; see cmnts

Comply By: 04/05/23

Surface and Equipment Sanitizers

Chlorine: = 0 PPM at Degrees Fahrenheit
Location: Dish machine
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: Red sanitary bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cheese
Temperature: 41 Degrees Fahrenheit - Location: Rear upright cooler
Violation Issued: No

Process/Item: Sausage
Temperature: 155 Degrees Fahrenheit - Location: Stove top
Violation Issued: No

Process/Item: Cheese, pkg
Temperature: 41 Degrees Fahrenheit - Location: 2 door cooler
Violation Issued: No

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

Dish machine:
The dish machine is a dual-unit sanitizer, and can be set up (according to the data plate) to do high temperature or chemical sanitizing. The unit failed to get to the operating temperatures for high temperature sanitizing (~120-130 deg F for washing and rinse, which was in line with the chemical sanitizing settings), however the unit also failed to test for chlorine sanitizer. There was a container of chlorine connected to a hose along with detergent and rinse aid, however when removing the front plate of the dish washer, I could only observe 2 pumps, which appeared to be detergent and rinse aid. It could be there is a third pump behind these for the sanitizer. It was just confusing why the unit didn't appear to be properly set-up for either type of cycle.

Regardless, the unit wasn't sanitizing using either method, and so staff were instructed to use the dish machine for washing and rinsing dishes, and then a bus tub or sanitized sink compartment could be used for the final sanitizing step. Discussed using the quat ammonia sanitizer available from the utility sink area (tested ~200 PPM) with a 1 min contact time/following label directions, and air drying.

Cooking equipment
MN 4626.0506 discusses cooking equipment. Depending on the menu and the definition of an Adult Care Facility and the extent of a menu change, this could be a discussion for HRD plan review.

Unable to verify if the oven met NSF/ANSI standards for cooking equipment, as there was no "bug" on the equipment labels, and no specification sheets had information online. Though, it seems like the oven is sort of a "stainless steel skinned" residential oven, made to look commercial. The operator may wish to consult original plans for the kitchen and see if the unit was approved, or if a unit was submitted as part of the plans and a different unit was instead purchased and installed. This is just a recommendation.

The requirement for cooking equipment also extends to things like electric griddles and rice cookers.

The ventilation hood had an individual NSF tag (not incorporated into the main product sticker).

Paper towels:
Dispenser empty, napkins provided. Can just provide a roll of regular paper towels, on a roller, they are more durable than paper napkins.

Discussed employee health and hygiene, illness exclusion, food cook temperatures, date marking for TCS foods, food source, food recalls, cross-contamination, sink dedication and usage (e.g. dedicate one sink compartment to handwashing only), monitoring temperatures in coolers, no service or raw or undercooked animal food for highly susceptible populations, date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days).

ServSafe (course) certificate posted; for information on CFPM requirements, please search "MDH CFPM"

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 1025231081 of 04/05/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Dorothy

Signed:_____
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us