Electronically Delivered

February 2, 2024

Licensee
Evergreen Place
220 3rd Street Northwest
Pine Island, MN 55963

RE: Project Number(s) SL30468015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 9, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines 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).

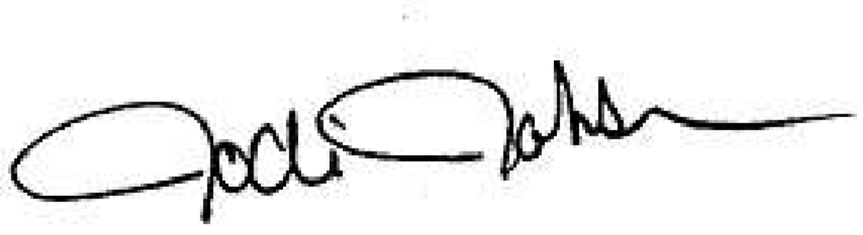
CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30468	A. BUILDING: _____ B. WING _____	01/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN PLACE	220 3RD STREET NW PINE ISLAND, MN 55963

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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: SL30468015 On January 8, 2024, through January 9, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 23 residents; 10 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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	0 580		

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0 580	Continued From page 2 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 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 engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living 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 of the residents). The findings include: On January 9, 2024, at 1:30 p.m. housing director (HD)-A stated they have not started a quality management program. HD-A stated she was aware of the requirement, but has not started it at this facility. The licensee's Quality Management Project	0 580		

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0 580	Continued From page 3 Policy dated August 1, 2021, indicated identified staff shall, using data collected from logged resident complaints, outcomes from MDH surveys or investigations, outcomes from resident satisfaction surveys, or other sources of data, select at least one area to focus on in the form of a quality improvement initiative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) that included an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and the person's risk of abusing other vulnerable adults for one of two residents	0 630		

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0 630	Continued From page 4 (R7). 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: R7 started receiving services from the licensee on April 30, 2021, with a diagnosis of dementia. R7's service plan dated December 14, 2022, indicated R7 needed assistance with medication management and assistance with activities of daily living (ADLs). R7 record lacked evidence of an IAPP. On January 9, 2024, at 10:45 a.m. unlicensed personnel (ULP)-H was observed administering R7's eye drops, dressing, and grooming. On January 9, 2024, at 3:30 p.m. registered nurse (RN)-B stated she was aware of the requirement and has been working on cleaning up the files. RN-B further stated she would look to see if an IAPP was created. The surveyor received an IAPP for R7 dated January 9, 2024. The licensee's Initial and On-going Nursing Assessment of Clients policy updated August 21, 2019, indicated an assessment of the client's areas of vulnerability and susceptibility to maltreatment and whether the client poses a risk	0 630		

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0 630	Continued From page 5 to other vulnerable adults will be completed and the RN will incorporate the abuse prevention plan and interventions into the client's comprehensive care plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment, and one of one	0 660		

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0 660	Continued From page 6 unlicensed personal (ULP-H) was screened and tested for active TB and retained documentation in the employee's file. 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: TB RISK ASSESSMENT AND TB PLAN On January 8, 2024, at 10:20 a.m. during the entrance conference, the surveyor asked for the licensee's TB facility risk assessment, and housing director (HD)-A stated they probably did not have a current risk assessment. TB EMPLOYEE SCREENING/TESTING ULP-H was hired October 30, 2023, to provide direct care services. On January 9, 2024, at 10:45 a.m. unlicensed personnel (ULP)-H was observed administering R7's eyedrops, and assisted with dressing and grooming. ULP-H employee record did not include evidence of a TB screening. After survey exit on January 10, 2024, at 1:12 p.m., HD-A sent an email indicating they were unable to locate a TB record for ULP-H.	0 660		

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0 660	Continued From page 7 The licensee's undated, TB prevention and control policy references statute 144A, Home care regulation, and indicated a written TB risk assessment will be completed annually. The policy also indicated that at the time of hire and prior to any contact with clients, all employees and all volunteers will be screened for Tuberculosis. After the baseline screening, the RN will review the TB symptoms annually with all employees and volunteer but additional testing will not be necessary as long as the TB risk assessment determines the agency to be in "low risk" category. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and	0 680		

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0 680	Continued From page 8 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all of the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: During the entrance conference on January 8, 2024, at 10:20 a.m., a request for the emergency preparedness manual was requested for later review. On January 9, 2024, at 1:48 p.m. housing director (HD)-A stated there has been a lot of staff turnover and she was not aware an EP risk assessment and plan had been created.	0 680		

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0 680	Continued From page 9 The licensee's Emergency Preparedness policy dated August 1, 2021, noted that the licensee's plan is to align with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z and is based on an assisted living based and community-based risk assessment, utilizing an all- hazards approach. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in	0 780		

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0 780	Continued From page 10 existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, 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: On January 8, 2024, at 12:00 p.m., survey staff toured the facility with maintenance (M)-F and maintenance consultant (MC)-E. During the tour, survey staff observed when smoke alarms were tested in resident apartments, the smoke alarms installed in the bedrooms and outside each sleeping area were not interconnected. During the facility tour interview on January 8, 2024, at 12:00 p.m., M-F and MC-E verified the smoke alarms were not interconnected so actuation of one alarm caused all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 800	Continued From page 11	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, 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: On January 8, 2024, at 12:00 p.m., survey staff toured the facility with maintenance (M)-F and maintenance consultant (MC)-E. During the facility tour survey staff observed the following: 1. In resident apartment 211, the smoke alarm installed in the living room did not work when tested. During the facility tour interview, M-F and	0 800		

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0 800	Continued From page 12 MC-E verified this smoke alarm was not working. 2. In resident apartment 208, a power strip was plugged into an extension cord. Extension cords must not be used as a substitute for permanent wiring. During the facility tour interview, M-F and MC-E verified the extension cord was being used improperly. 3. The inspection tag attached to the reduced pressure device (RPZ) in the mechanical room was dated 1996. During the facility tour interview, M-F and MC-E verified the RPZ had not been inspected annually by certified personnel as required. During an interview on January 8, 2024, at 2:30 p.m., with licensed assisted living director (LALD)-D and housing director (HD)-A, the current operating condition of the tub in the spa room was discussed. LALD-D and HD-A verified the tub was not maintained in operating condition and had not worked for the past ten years. LALD-D and HD-A explained showers were installed in all resident apartments. LALD-D and HD-A stated the spa room was kept locked and the tub was not offered as a service at this facility. 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;	0 810		

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	30468	A. BUILDING: _____ B. WING _____	01/09/2024

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0 810	Continued From page 13 (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 record review and interview, the licensee failed to provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive	0 810		

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0 810	Continued From page 14 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 January 8, 2024, licensed assisted living director (LALD)-D and housing director (HD)-A provided documents on the fire safety and evacuation plans (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. EduCare training records from 20203 on Emergency Preparedness for nine employees were provided. No training records were provided to support training on the FSEP had been completed in the past year. During an interview with survey staff on January 8, 2024, at 2:30 p.m., LALD-D and HD-A verified the required employee training frequency was not met and explained employees were trained upon hire and annually on the facility fire safety and evacuation plan but records were not available to support this training had been completed. Record review indicated the licensee failed to provide fire safety and evacuation training to all residents at least once per year as evident by the lack of training documentation. Resident fire safety training records were provided. Seven resident names were recorded in 2023 and three resident names were recorded in 2022. During an interview with survey staff on January 8, 2024, at 2:30 p.m., LALD-D and HD-A verified the annual resident training frequency was not met. DRILLS Record review indicated the licensee failed to	0 810		

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0 810	Continued From page 15 conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by no drill records. During an interview with survey staff on January 8, 2024, at 1:35 p.m. LALD-D stated an employee evacuation drill was scheduled for next week but no employee evacuation drills had been completed in the past year. During an interview with survey staff on January 8, 2024, at 2:30 p.m., LALD-D and HD-A verified the employee evacuation drill frequency had not been met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction 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 with the assisted living license for one of one employee	01290		

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01290	Continued From page 16 (unlicensed personnel (ULP)-H). 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-H was hired October 30, 2023, to provide direct care services. On January 9, 2024, at 10:45 a.m. unlicensed personnel (ULP)-H was observed administering R7's eyedrops, and assisting with dressing and grooming while working independently. ULP-H's employee record contained a background study affiliated with another license owned by the same licensee dated November 20, 2023. ULP-H's employee record lacked evidence the licensee affiliated a background study for their license. On January 9, 2024, at 2:50 p.m. human resources assistant (HRA)-I and housing director (HD)-A stated ULP-H's background study was affiliated with their other location and was not aware of the requirement. The licensee's Background Studies Policy dated August 2023, indicated using the MN DHS NETStudy online program, the licensee will	01290		

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01290	Continued From page 17 initiate a background study on all employees being considered for hire. Once an approved background study has been received, staff may act independently with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (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;	01370		

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01370	Continued From page 18 (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 review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP-H). 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 January 8, 2024, at approximately 10:20 a.m., housing director (HD)-A and RN-B stated new employee training consisted of Educare training (electronic training with assigned independent reading) and training by staff at the attached nursing home prior to working for the licensee at the Assisted	01370		

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01370	Continued From page 19 Living. ULP-H was hired October 30, 2023, to provide direct care services. On January 9, 2024, at 10:45 a.m. ULP-H was observed assisting R5 with placement of her hearing aids. ULP-H stated she was trained on Educare and then shadowed another ULP for three or four days. ULP-H stated she was not trained at the attached nursing home prior to working independently at the assisted living. ULP-H's employee record lacked evidence ULP-H had been trained by a RN and demonstrated they were competent to assist with placement of hearing aids. In addition, ULP-H's record lacked evidence of competency in the following required areas: -haircare and bathing -care of teeth, gums, and oral prosthetic devices -dressing and assisting with toileting On January 9, 2024, at 3:15 p.m. RN-B stated competency training for ULP-H was in medication management only and had not been competency tested in anything else. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 20 be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for one of two residents (R7) as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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	01620		

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01620	Continued From page 21 situation has occurred only occasionally). The findings include: R7 began receiving services on April 30, 2021, under the facility's assisted living license. R7's diagnoses included dementia. R7's Service Plan dated January 1, 2023, indicated she received services to include medication administration, and assistance with activities of daily living (ADL). On January 9, 2024, at 10:45 a.m. unlicensed personal (ULP)-H was observed administering R7's morning medication and assisting with grooming. R7's record indicated the assessments by the registered nurse (RN) had completion dates as follows: - March 13, 2023. - June 21, 2023 (100 days from the previous assessment) - January 9, 2024 (203 days from the previous assessment) On January 9, 2024, at 3:15 p.m. RN-B stated she was aware assessments were not to exceed 90 days, but was behind on keeping up with the assessments. The licensee's Initial and On-going Nursing Assessment of Clients Policy revised August 21, 2019, indicated the RN will determine the frequency of re-assessments based on the client's needs, with the frequency between assessments not to exceed 90 days.	01620		

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01620	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was started receiving services on March 1, 2021, with a diagnosis of dementia, personality disorder, and diabetes.	01710		

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01710	Continued From page 23 R2's service plan last updated December 20, 2023, indicated R2 received assistance with medication management. R2's medication summary dated January 8, 2024, indicated R2 received the following medications: Coumadin 7.5 milligrams (mg) used for irregular heart rate. Divalprex 250 mg used for personality disorder. Gabapentin 300mg used for nerve pain. Metformin 500mg used for diabetes. R2's last assessment dated October 10, 2023, indicated R2 had a complex medication regimen; however, it failed to include the required contents including: indications for use, side effects, and contraindications of medications. On January 9, 2024, at 12:21 p.m. RN-B stated she was aware of the requirement, but R2's record did not include a current medication assessment because she was "behind." The licensee's Initial and On-going Nursing Assessment of Clients Policy revised August 21, 2019, indicated a specific assessment of the client's need for medication management services will be completed. The policy failed to mention the medication assessment was required at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 24 (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 ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R7) with siderails. This practice resulted in a level two violation (a violation that did not harm a client/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: R7 began receiving services on April 30, 2021, under the facility's assisted living license. R7's diagnoses included dementia. R7's Service Plan dated January 1, 2023, indicated she received services to include medication administration, and assistance with activities of daily living (ADL). On January 9, 2024, at 10:45 a.m. unlicensed personal (ULP)-H was observed to administer R7's eye drops. R7's was observed sitting on the side of her hospital bed with the top right siderail	02310		

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02310	Continued From page 25 in the down position. R7 's record included a siderail assessment dated September 18, 2023, which indicated the client and family received the FDA bedrail brochure and risk versus benefits of side rail use was discussed. The siderail assessment lacked evidence of measurements. On January 9, 2024, at 12:21 p.m. registered nurse (RN)-B stated R7's siderail assessment did not include measurements and she was not aware siderail measurements were required. 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 four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When 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." The licensee's Assessment Regarding Safe Use of Assistive Devices Policy last revised August 23, 2019, indicated the RN's initial assessment and	02310		

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02310	Continued From page 26 re-assessments will include an evaluation of a client's ability to safely use any assistive device. The policy did not reference the required measurements as part of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	02310		

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul
651-201-4500

Type: Full
Date: *01/08/24*
Time: 13:05:12
Report: 7962241011

Food and Beverage Establishment Inspection Report

Location:
Evergreen Place
220 3rd Street Nw
Pine Island, MN55963
Goodhue County, 25

Establishment Info:
ID #: 0039376
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073568585
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.

4-200 Equipment Design and Construction

4-203.12 ***** Priority 2 *****

MN Rule 4626.0560 Replace ambient air and water temperature measuring devices that are not accurate to plus or minus 3 degrees F.

INDEPENDENT THERMOMETER IN SINGLE DOOR COOLER READING 12 DEG, EXTERNAL THERMOMETER AND PAT OF BUTTER 40 DEG, GALLON OF MILK 39 DEG

Comply By: 01/15/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

PROBE OF FOOD THERMOMETER VISIBLE FOOD DEBRIS AND STICKY

Comply By: 01/08/24

5-200C Plumbing: Maintenance, fixture location

5-205.13 ***** Priority 2 *****

MN Rule 4626.1120 Inspect, test and maintain water treatment and backflow prevention devices according to the manufacturer's instructions and as necessary to prevent device failure. The person in charge must maintain records of inspection and service of water treatment and backflow prevention devices.

WATER FILTER FOR COFFEE MACHINE DATED 11-30-2018, NO DATE OF INSTALLATION ON WATER/ICE DISPENSER FILTER. REPLACE FILTER/WATER TREATMENT DEVICES A MINIMUM OF ANNUALLY, MARK WITH DATE OF EACH REPLACEMENT

Comply By: 01/15/24

Type: Full
Date: *01/08/24*
Time: 13:05:12
Report: 7962241011
Evergreen Place

Food and Beverage Establishment Inspection Report

4-400 Equipment Location and Installation

4-402.12A

MN Rule 4626.0730A Install floor-mounted equipment sealed to the floor or on six inch legs.

SINGLE DOOR UPRIGHT FREEZER NOT SEALED TO FLOOR, ELEVATED ON 6 INCH LEGS, OR CASTERS

Comply By: 02/05/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200ppm at Degrees Fahrenheit
Location: wiping cloth bucket
Violation Issued: No

Hot Water: = at 166 Degrees Fahrenheit
Location: waterproof thermometer sent through machine
Violation Issued: No

Hot Water: = at 190 Degrees Fahrenheit
Location: sanitizing rinse thermometer on dish washing machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 12 Degrees Fahrenheit - Location: independent thermometer inside single door cooler
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: gallon milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: butter pat
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: external thermometer
Violation Issued: No

Process/Item: Upright Cooler
Temperature: -18 Degrees Fahrenheit - Location: independent thermometer inside single door freezer
Violation Issued: No

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

Vomit/Fecal procedure - yes
CFPM - yes
Ill Employee Log - yes
Small Diameter Thermometer - yes
Thermometer wipes - yes
Test Strips - yes

Food and Beverage Establishment Inspection Report

Signs for Hand Wash Sinks - yes
Water Proof Thermometer for Dish washing machine - yes

Establishment Info:

Report emailed to:

Sarah Wangen, Evergreen Dietary Director, dietary@pinehavencommunity.org

Tracy Fearon, MDH/HRD Nursing Evaluator, Tracey.Fearon@state.mn.us

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 7962241011 of 01/08/24.

Certified Food Protection Manager: Sarah Wangen

Certification Number: FM100641 Expires: 09/10/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Sarah Wangen
Dietary Director

Signed: Heather Flueger

Heather Flueger
Public Health Sanitarian
Rochester District Office
507-208-3096
heather.flueger@state.mn.us

Report #: 7962241011

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food Pools and Lodging Services Section
625 Robert St N
St. Paul

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

Date 01/08/24
Time In 13:05:12
Time Out

	Address	City/State	Zip Code	Telephone
Evergreen Place	220 3rd Street Nw	Pine Island, MN	55963	5073568585

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0039376		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

			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	X	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		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51	X	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:** 01/08/24

Inspector (Signature) Hunt Flueger