DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 3, 2023

Licensee
Copperfield Hill The Lodge
4020 Lakeland Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL29966015

Dear Licensee:

On April 27, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 16, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

HHH

Electronically Delivered

March 22, 2023

Licensee
Copperfield Hill The Lodge
4020 Lakeland Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL29966015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 16, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please email 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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

Jess Schoenecker, Supervisor
State Rapid Response Team / State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970 / P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-215-6894 / 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29966	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPERFIELD HILL THE LODGE	4020 LAKELAND AVENUE NORTH ROBBINSDALE, MN 55422

(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: SL29966015-0 On February 13, 2023, through February 15, 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 91 active residents receiving services under the Assisted Living with Dementia Care license. On February 16, 2023, the immediacy of correction order 2310 has been removed, however non-compliance remains at a scope and level of I.	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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 14, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510		

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0 510	Continued From page 2 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control. This deficient practice had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: CARES On February 14, 2023, at 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-G come out of a resident room with gloves on, walked down the memory care hallway into the dining room and without removing soiled gloves and performing hand hygiene, ULP-G started setting up the tables for breakfast.	0 510		

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0 510	Continued From page 3 On February 14, 2023, at 7:40 a.m., the surveyor observed in the memory care hallway a trash bag of soiled briefs on a chair with some unbagged linen. At 8:46 a.m., ULP-H stated someone must have left the trash in the hallway by accident. ULP-H also stated all trash should be taken out of resident rooms and immediately taken to the trash room for disposal. On February 14, 2023, at 9:00 a.m., ULP-G stated handing washing is completed when hands are soiled, before and after medication administration, and before touching foods. MEDICATION On December 20, 2022, at 7:19 a.m., the surveyor observed ULP-H wash hands, don gloves and complete blood glucose monitoring for R4 in the memory care dining room. ULP-H did not remove gloves until lancet and test strip was removed at the medication cart and placed into the sharps container. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 30, 2020, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. The licensee's Hand Washing policy dated August 1, 2022, indicated proper hand washing/hygiene technique must be used at all times when indicated. The policy also indicated the use of gloves does not eliminate the need to wash hands and alcohol based hand rub can be used too.	0 510		

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0 510	Continued From page 4 No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency documentation was maintained for one of two registered nurse (RN)-B to include all required content.	0 650		

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0 650	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: RN-B was hired on July 8, 2019, under the comprehensive license and started providing assisted living services August 1, 2021. RN-B's record lacked documentation of completed annual performance reviews, orientation, and annual training to include review of provider's policies and procedures. On February 15, 2023, at 10:00 a.m., registered nurse (RN)-A indicated RN-B's record lacked documentation of the required training. RN-A stated performance reviews, orientation and annual training were completed in all required topics but could not locate them in the licensee's system. The licensee's Personnel Records policy dated August 1, 2021, indicated personnel records will be kept up-to-date, well organized, and confidential and will comply with all applicable laws. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		

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0 660	Continued From page 6	0 660		
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 establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing and screening for three of four employees (registered nurse (RN)-B, unlicensed personnel (ULP)-G, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 7 The findings include: The Facility TB Risk Assessment dated March 1, 2022, identified the facility was at a low risk for transmission. RN-B was hired on July 8, 2019, under the comprehensive license and started providing assisted living services August 1, 2021. RN-B's employee record included a Baseline TB Screening Tool dated July 10, 2019, and a chest x-ray dated June 19, 2019. RN-B's record lacked a positive TB test prior to completing a chest x-ray. ULP-G started employment with licensee January 25, 2023. ULP-G's employee record included a Baseline TB Screening Tool dated January 6, 2023, and a negative Tuberculin skin test (TST) first step dated January 9, 2023. ULP-G's record lacked a TST second step as required. ULP-H started employment with licensee October 10, 2022. ULP-H's employee record included a Baseline TB Screening Tool dated October 13, 2022, and a negative TST first step dated October 12, 2022. ULP-H's record lacked a TST second step as required. Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 indicated baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA.	0 660		

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0 660	Continued From page 8 RN-A verified RN-B's record included a chest x-ray with no positive TB test. RN-A stated the licensee used to do only chest x-ray and changed in the last two years to do blood work. RN-A verified ULP-H and ULP-G's records included only the first step of the TST. The licensee's TB Prevention and Control policy dated August 1, 2022, indicated this agency will establish and maintain a TB prevention and control program based on the most current guidelines issued by the CDC. The Minnesota Department of Health guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings (see 06-009) will be followed. 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	0 680		

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0 680	Continued From page 9 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 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 (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. 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: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - Maintain and Annual EP Updates; - Emergency plan Program Patient Population; - Development of EP Policies and Procedures; - Subsistence Needs for Staff and Patients;	0 680		

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0 680	Continued From page 10 - Procedures for Tracking of Staff and Patients; - Policies and Procedures for Medical Documents; - Policies and Procedures for Volunteers; - Roles under a Waiver Declared by Secretary; - Primary/Alternate Means for Communication; - Methods for Sharing Information; - Sharing Information on Occupancy/Needs; - LTC Family Notifications; - Emergency Prep Training and Testing; - Emergency Prep Training Program; and - Emergency Prep Testing Requirements. On February 15, 2023, at 11:45 a.m., RN-A stated the EPP lacked the required content. RN-A stated licensee's maintenance director could be well suited to understand the program. RN-A also stated the licensee was continually updating records to reflect requirements. 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;	0 780		

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COPPERFIELD HILL THE LODGE	4020 LAKELAND AVENUE NORTH ROBBINSDALE, MN 55422

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0 780	Continued From page 11 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 15, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-C and Director of Maintenance (DM)-E. During the	0 780		

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0 780	Continued From page 12 facility tour, it was observed that the sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit, so the actuation of one alarm would cause all alarms to operate. During the interview, DM-E stated that this was consistent with all resident units throughout the facility. This deficient condition was visually verified by DM-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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 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	0 800		

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

Findings include:

On February 15, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Licensed Assisted Living Director (LALD)-C and Director of Maintenance (DM)-E. During the facility tour, survey staff observed the following items:

In the Laundry room on the ground floor, it was observed that extensive mold or similar black substance on the ceiling and on the supply air grille. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the ground floor served by that equipment.

In the break room on the ground floor, it was observed that extensive mold or similar black substance on the ceiling and on the supply air grille. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the ground floor served by that equipment. It was also observed that the door was propped open with a rubber wedge. The kick-down doorstop will prevent the door from closing in the event of a fire.

In the community room on the ground floor, it was observed that the door from the corridor was propped open with a kick-down door stop. The

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0 800	Continued From page 14 kick-down doorstop will prevent the door from closing in the event of a fire. In the dining room on the ground floor, it was observed that there were many dark brown stains on the sheetrock ceiling with evidence of water damage. It was also observed that the extensive mold or similar black substance on the ceiling and around every supply air grille in the room. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the ground floor served by that equipment. Outside the dining room exit door, it was observed that the burnt used cigarettes were being disposed of without a proper disposal container. The outdoor space stair to the egress gate was obstructed by snow and was not maintained to keep an all-weather walk. The door was identified as an exit, and an exit sign was installed above the door. In resident unit 61, it was observed that the resident unit door was propped open with a kick-down door stop. The kick-down doorstop will prevent the door from closing in the event of a fire. In the corridor outside of resident unit 61, it was observed that the 2x4 acoustic ceiling tile was falling, and the ceiling grids were not securely installed. In the trash room on the ground level, it was observed that there were several holes in the rated sheetrock ceiling. It was also observed that the gaps around pipes and utility penetrations did	0 800		

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0 800	Continued From page 15 not have fire sealant. In the corridor on the ground floor, it was observed that the fire extinguisher cabinet door was missing glass, exposing sharp metal edges. In the Electrical room on the ground floor, it was observed that multiple plug strips were daisy chained and were all attached by a multi-tap plug device, with all these elements creating a fire hazard. In resident unit 47, it was observed that dark brown stains were on the sheetrock ceiling with evidence of water damage. Outside the main entrance door, it was observed that the burnt used cigarettes were being disposed of without a proper disposal container. In resident unit 146, the wall-mounted air conditioning unit was connected to a power stipe and was not connected to the wall-mounted outlet. During the interview, DM-E stated that he assumed the wall outlet provided 210/220 volts, but the installed air conditioning unit required 110 volts, so someone from the facility connected the air conditioning unit to the power strip. It was also observed that the room had considerable damage to the sheetrock ceiling, with evidence of water damage. In the laundry room on the second floor, it was observed a large hole in the sheetrock ceiling from repair. In the dining/common area on the memory care on the second floor, survey staff observed the following items: It was observed the restroom door hinges were	0 800		

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0 800	Continued From page 16	0 800		

pulled away from the frame, and the door was loosely attached to the frame.
It was observed that the metal floor transition strip was loose and missing a couple of screws. The uneven finish condition created a tripping hazard for all residents.
It was observed that near the serving kitchen, vertical wood trim was not secured to the wall, and the wood base was missing.
It was observed the radiant heater cover was broken, exposing sharp metal edges.
It was observed a hole in the ceiling from ceiling equipment removal.

In the corridor on the third floor, it was observed that the fire extinguisher cabinet door was missing glass, exposing sharp metal edges.

In resident unit 349a, it was observed that the air transfer grill was loose and missing screws, and the resident unit door was propped open with a rubber wedge. The rubber wedge will prevent the door from closing in the event of a fire.

In resident unit 346, it was observed that the room had considerable damage to the sheetrock ceiling with evidence of water damage. During the interview, DM-E stated that there was a water leak from the unit above.

At the perimeter of the trash chute doors on the third floor and fourth floors, it was observed that the wood block was exposed, and the gypsum board was not installed up to the trash chute door jamb. This chute and perimeter assembly are part of a fire barrier and must maintain fire resistance integrity.

In resident unit 455, it was observed the radiant heater cover was cut above zone value, exposing

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0 800	Continued From page 17 sharp metal edges. In resident unit 457, it was observed that the resident unit door was propped open and had not closed automatically. The automatic door closers were not installed, but spring hinges were installed at the door jamb. The door is required to automatically close and latch to maintain the fire barrier from the corridor. During the interview, DM-E stated that this was consistent with many resident units throughout the facility. In resident unit 456, it was observed that the resident unit door was propped open with a kick-down door stop. The kick-down doorstop will prevent the door to close in the event of a fire. It was also observed the radiant heater cover was cut, exposing sharp metal edges. In the resident unit door 452, it was observed that the door was sticking badly, and the crooked door frame made it difficult to open. The resident from the unit mentioned that she was stuck inside a couple of times due to the door and frame condition. During the interview, DM-E stated that they are dealing with building settlement, and the door has been a problem. In resident unit 452, it was observed that the room had considerable damage to the sheetrock ceiling with evidence of water damage. During the interview, DM-E stated that there was a water leak from the unit above. DM-E visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		

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0 970	Continued From page 18	0 970		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents living at 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 the potential to affect a large portion or all the residents). The findings include: On February 13, 2023, at 10:30 a.m., during the entrance conference, the licensee provided a survey binder that included the licensee's current Assisted Living Contract. The licensee's Assisted Living Contract, included the following language indicating a waiver of	0 970		

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0 970	Continued From page 19 liability: Page 21, section 27 "Liability" - "Provider is not responsible for any loss, damage or injury that is done to Resident's property (including personal effects and medical equipment such as walkers, canes, dentures and hearing aids) in the Apartment or Community caused by fire, water, explosion or any other cause other than by proven willful misconduct by Provider's employees." On February 15, 2023, at 2:19 p.m., registered nurse (RN)-A sent an email indicating "Regarding the Waiver of Liability, what is prohibited by law is a blanket waiver of liability that absolves the provider of liability for failure to meet the required standards of care. Our language is not a blanket waiver of liability." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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	01290		

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01290	Continued From page 20 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 interview and record review, the licensee failed to ensure a background study was completed as required for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D began employment with the licensee on June 04, 2018, under the comprehensive license and started providing assisted living services on August 1, 2021. ULP-D's record included a background study dated July 29,2021, affiliated to the licensee's former health facility identification (HFID) 21574. ULP-D's employee record lacked evidence the licensee submitted a background study for ULP-D under the current license and affiliated to the current HFID number. On February 14, 2023, at 11:30 a.m., registered nurse (RN)-A verified the licensee had not affiliated ULP-D's employee background to the current license.	01290		

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01290	Continued From page 21 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted change in condition reassessments for one of five residents (R1).	01620		

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01620	Continued From page 22 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee on September 30, 2021. R1's diagnoses included chronic obstructive pulmonary disease (COPD) and asthma. R1's service plan dated August 5, 2022, indicated R1 received assistance with medication assistance, shower/bathing, housekeeping, and meal delivery. R1's assessment dated December 9, 2022, indicated R1 was independent with transfer, toileting, and needed reminders for grooming and hygiene. The assessment also indicated R1 needed assistance with oxygen placing canula in nose. R1's Resident Note dated January 31, 2023, written by registered nurse (RN)-B, indicated "staff, I have added the following services for [R1] AM/PM cares, toileting, transfer assist, and a couple more reassurance checks." R1's record lacked evidence R1 was reassessed after change of condition. On February 14, 2023, at 9:50 a.m., the surveyor observed hospice nurse (HN)-I requested unlicensed personal (ULP)-D to administer pain	01620		

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01620	Continued From page 23 medication for R1 as he was in pain. When ULP-D arrived in the room, R1 was sitting in the toilet and HN-I stated R1 had dirty bedding. HN-I further stated R1 reported he had a fall three days ago and was going to discuss with the licensee's nurse concerning the fall. On February 14, 2023, at 11:00 a.m., the surveyor observed ULP-D help R1 to reposition oxygen on R1's nose. When surveyor asked ULP-D what the oxygen flow rate was, ULP-D stated he was not sure how much oxygen R1 needed. ULP-D further explained ULPs were to help R1 reposition the oxygen to ensure it was correctly placed. On February 15, 2023, at 12:30 p.m., visitor (V)-K stated R1 was on oxygen but could not keep it on his nose. Also, V-K shared email correspondence with license which indicated "The oxygen has not been staying on his face. I don't know if there is something else we could use that could fit his face better. Please let the staff know to keep checking making sure the oxygen is on his face. The machine is running but the cords on his bed." On February 15, 2023, at 3:26 p.m., ULP-J stated R1 was independent but with decline in health the ULPs were asked to toilet R1. ULP-J also stated this was communicated to them in person and in Rtask (an electronic charting software). ULP-J further stated oxygen therapy was not one of the services added to the care plan for ULPs to complete. On February 16, 2023, at 12:17 p.m., RN-A verified the change in condition assessment had not been completed for R1, and care plan was missing oxygen therapy.	01620		

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01620	Continued From page 24 The licensee's Monitoring of Clients and Their Services policy dated, August 1, 2021, indicated "Change in condition requiring a reassessment means a change from the most recent assessment in a client's baseline in physical, cognitive, behavioral or functional status that is expected to last longer than 30 days." No further information provided TIME PERIOD TO CORRECT: Seven (7) days	01620		
01650 SS=D	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; and (iv) the circumstances in which emergency	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29966	A. BUILDING: _____ B. WING _____	02/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPERFIELD HILL THE LODGE	4020 LAKELAND AVENUE NORTH ROBBINSDALE, MN 55422

(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
01650	Continued From page 25 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident's service plan included the required content for one of five residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1's Service Plan Agreement dated August 5, 2022, indicated R1 received services to include assistance with shower, medication management, and housekeeping. R1's Service Plan lacked identification of oxygen care services. R1's diagnoses included but were not limited to chronic obstructive pulmonary disease (COPD). R1'spPhysician order dated February 15, 2022, effective date December 9,2022, indicated "Oxygen Nasal cannula 2 LPM continuous COPD." On February 14, 2023, at 11:00 a.m. the surveyor observed unlicensed personnel (ULP)-D assist	01650		

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01650	Continued From page 26 R1 reposition the oxygen to ensure it was correctly placed. On February 16, 2023, at 12:17 p.m., registered nurse (RN)-A confirmed R1's service plan lacked identification of oxygen. RN-A stated the R1's service plan should have included all services provided by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01820 SS=E	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a current written or electronically recorded prescription for all prescribed medications that the assisted facility was managing for two of five residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be	01820		

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01820	Continued From page 27 pervasive). The findings include: R4's Service Plan (Waiver)- Addendum to Contract signed May 16, 2019, indicated R4 received assistance with laundry, linen change, medication administration, medication management/setup-complex, blood glucose monitoring, and reassurance checks. R4's Medication Administration Summary for January 1, 2023, through January 31, 2023, indicated R4 was receiving the following medications: acetaminophen 500 milligram (mg) two tablets by mouth three times daily, polyethylene glycol 17 grams (g) daily in four ounces of water, Lantus Solostar 100 units/milliliter (ml) daily inject 10 units subcutaneously every morning, and Ativan one tablet every four hours as needed for anxiety or agitation. R5's Service Plan (Waiver)- Addendum to Contract signed December 13, 2022, indicated R5 received assistance with laundry pick up/put away, linen change, medication administration, medication management/setup-complex, and reassurance checks. R5's Medication Administration Summary for January 1, 2023, through January 31, 2023, indicated R5 was receiving the following medications: acetaminophen 500 mg one tablet by mouth three times daily, cephalexin take 1 tablet by mouth twice a day x 5 days, Mucinex 600 mg Daily give one tablet by mouth two times daily, Senna 8.6 mg laxative tablet take one tablet by mouth every Monday, Wednesday, and Friday, Seroquel give 1/2 tablet (12.5 mg) by mouth daily,	01820		

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01820	Continued From page 28 haloperidol 0.5 mg tablet take one tablet by mouth every four hours as needed, and lorazepam tablet 0.5 mg take one tablet by mouth every six hours as needed. On February 15, 2023, at 2:50 p.m., registered nurse (RN)-A stated the licensee administered medications with written prescription for R4 and R5. RN-A stated the licensee was trying to trace the written orders for the residents above and will email them to the evaluator. The licensee's Requesting and Receiving Medication Prescriptions and Refills dated August 1, 2021, indicated a current, written prescriber's prescription must be obtained for any medication, including over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication or providing other medication management services for a client. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01890		

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01890	Continued From page 29	01890		

review, the licensee failed to discard expired medication for two of two residents (R4, R15); failed to ensure medications were labeled with legible information for one of one resident (R14); and failed to ensure time sensitive medications were labeled with the date opened for three of three residents (R4, R9, R12).

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:

EXPIRED MEDICATIONS
On February 14, 2023, at 8:01 a.m., the surveyor observed the memory care unit medication cart and observed the following expired medications:
- R4 tussin DM cough syrup expired July 7, 2021;
- R15 deep sea saline nasal spray expired April 19, 2022; and
- R15 milk of magnesia 400 milligram (mg)/5 milliliter (ml) suspension expired December 14, 2022.

PRESCRIPTION LABEL
On February 14, 2023, at 8:10 a.m., the surveyor observed the memory care unit medication cart and observed the following unlabeled medications:
- ammonium lactate 12%;
- phytoplex nourishing cream; and
- dermal wound cleanser.

TIME SENSITIVE MEDICATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 30 On February 14, 2023, at 7:02 a.m., the surveyor observed unlicensed personnel (ULP)-F prepare and administer insulin to R9. R9's insulin pen lacked an open date or an expiration date. On February 14, 2023, at 8:13 a.m., the surveyor observed ULP-H prepare and administer insulin to R12. R12's insulin pen lacked an open date or an expiration date. On February 14, 2023, at 8:31 a.m., the surveyor observed ULP-H prepare and administer insulin to R4. R4's insulin pen lacked an open date or an expiration date. On February 14, 2023, at 8:40 a.m., ULP-H stated all time sensitive medications are labeled at time of opening. ULP-H stated maybe the ULP who opened the insulin forgot to label them. ULP-H stated the medication administration record indicated to dispose insulin pens 28 days after opening. On February 14, 2023, at 9:50 a.m., registered nurse (RN)-A stated the expectation is for staff to label all insulin pens when they are opened. RN-A stated the licensee will ensure staff have the supplies they need in each medication cabinet to label medications all time. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized	01970		

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01970	Continued From page 31 prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed ensure up-to-date written or electronically recorded orders were maintained for one of one resident (R4) who received a treatment. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's diagnoses included dementia, anemia, essential hypertension, and type 2 diabetes with diabetic chronic kidney disease. R4's Service Plan (Waiver)- Addendum to Contract signed May 16, 2019, indicated R4 received assistance with laundry, linen change, medication administration, medication management/setup-complex, blood glucose monitoring, and reassurance checks. On February 14, 2023, at 8:31 a.m., the surveyor	01970		

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01970	Continued From page 32 observed ULP-H prepare and check blood glucose and administer insulin injection to R4. R4's nursing assessment dated November 17, 2022, indicated R4 needed help with insulin administration and blood glucose monitoring per schedule. R4's record lacked a current written or electronically recorded order for blood glucose monitoring. On February 15, 2023, at 2:50 p.m., registered nurse (RN)-A stated the licensee administered treatments with written prescription orders for all residents. RN-A stated the licensee was trying to trace the written orders for R4 and will email them to the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for three	02310		

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02310	Continued From page 33 of three residents (R2, R7, R8) who utilized consumer portable bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 On February 15, 2023, at 9:30 a.m., the surveyors observed R2's bed had a siderail on the left side, which was not attached to the bed. The siderail was an upside down "U" shape with rails proceeding between the mattress and box spring. The surveyor grasped the siderail and noted the siderail was not secured to the bed and did move when pulled and pushed on with force. R2 admitted on March 05, 2019, with diagnoses including chronic kidney disease stage 3 and bone density structure disorder. R2's Service Plan dated August 24, 2022, indicated R2 received services including medication management and assistance with activities of daily living. R2's Bed Safety Assessment document dated November 17, 2022, indicated R2 use side rail for getting in and out of bed safely. The description of the grab bar included partial side rail (left) and partial side rail (right) measuring 20 inches wide by 31.5 inches tall. R2 used bed rail for fear of	02310		

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02310	Continued From page 34	02310		

rolling out of bed, transfers in and out of bed, and rolling side to side. The assessment indicated R2/responsible party declined evaluation, resident was evaluated by physical/occupational therapy (PT/OT).

R2's 90-day Clinical Update Assessment dated November 17, 2022, indicated R2 was using side rails to get in and out bed safely. R2's assessment indicated PT/OT installed and resident aware of risks with bedrails.

R2's record lacked evidence the bed rail was installed, maintained, and used per manufacturer's instructions

R7
On February 15, 2023, at 9:37 a.m., the surveyors observed R7's bed had a siderail on the right side, which was not attached to the bed. The siderail was an upside down "U" shape with rails proceeding between the mattress and box spring. The surveyor grasped the siderail and noted the siderail was not secured to the bed and did move when pulled and pushed on with force.

R7 admitted on March 05, 2019, with diagnoses including acute kidney failure, muscle spasm, and obstructive sleep apnea.

R7's Service Plan dated January 17, 2023, indicated R7 received services including medication management, morning cares, and assistance with showering or bathing.

R7's Bed Safety Assessment dated January 26, 2023, indicated R7 was using side rails to aid in turning and repositioning while in bed. R2's assessment indicated PT/OT affixed side rail to bed and resident declined nursing evaluation.

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02310	Continued From page 35 R7's 90-day Clinical Update Assessment dated January 26, 2023, indicated R7 was using side rails because of pain. R7's medical record lacked documentation of education of the risks and benefits associated with the use of siderail and evidence the bed rail was installed, maintained, and used per manufacturer's instructions R8 On February 15, 2023, at 9:40 a.m., the surveyor observed an oval shaped halo safety ring attached to a vertical pole measuring approximately 25 inches long when registered nurse (RN)-B lifted R8's mattress and the surveyor observed the pole was screwed to a flat wooden board measuring approximately 26 by 38 inches which was between the mattress and the bed frame. The board in turn was fastened to the other side of the bed by a strap. R8's diagnoses included atrial fibrillation, hypertension, dizziness, cerebrovascular accident (CVA) and heart failure. R8's service plan dated November 11, 2022, indicated R8 received services to include housekeeping, laundry, medication administration, medication set up, reassurance checks, and shower assistance. R8's Bed Safety Assessment document dated January 25, 2023, indicated R8 requested the use of bed handle/grab bar. The description of the grab bar included partial grab bar on the left side of bed measuring 10 by 20 inches. R8's 90-day Clinical Update Assessment dated	02310		

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02310	Continued From page 36 January 25, 2023, indicated R8 was using grab bars because of pain and weakness. R8's assessment indicated R8 was informed to notify the nurse if R8 changed or added to their bed safety device. R8's medical record lacked documentation of education of the risks and benefits associated with the use of siderail and evidence the bed rail was installed, maintained, and used per manufacturer's instructions. On February 15, 2023, at 9:50 a.m., registered nurse (RN)-A acknowledged side rails were in place for R2, R7 and R8 and stated residents declined evaluation. RN-A stated siderails are provided by residents and residents' family members, and licensee advice against the use of portable bed rails. RN-A stated the licensee does not approve or install siderails and they do not have the manufacturers' instructions. RN-A stated the licensee completes the siderail assessments and education. RN-A indicated the residents, residents' family members, or PT/OT were responsible for installing the siderails. The Consumer Product Safety Commission (CPSC) dated September 17, 2015, indicated, "Recall of Adult Portable Bed Handles Due to Serious Entrapment and Strangulation Hazards. When attached to an adult's bed without the use of safety retention straps, the handle can shift out of place, creating a dangerous gap between the bed handle and the side of the mattress. This poses a serious risk of entrapment, strangulation, and death." The licensee's Assessing the Safety of Side Rails policy dated May 17, 2022, indicated "The resident, resident representatives and provider	02310		

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02310	Continued From page 37 who installed the device are responsible for ensuring adherence to manufacturer's instructions." TIME PERIOD FOR CORRECTION: Immediate On February 16, 2023, the immediacy of correction order 2310 has been removed as confirmed by evaluation supervisor review, however non-compliance remains at a scope and level of I.	02310		

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

Type: Full
Date: *02/14/23*
Time: 09:37:25
Report: 1024231007

Food and Beverage Establishment Inspection Report

Location:
Copperfield Hill The Lodge
4020 Lakeland Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0038858
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632771001
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.

5-200B Plumbing: cross connections

5-203.14I ** Priority 1 **

MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.

OBSERVED WYE CONNECTOR DIRECTLY CONNECTED TO FAUCET WITH AVB IN MOP SINK CLOSET OF THE LODGE. ADVISED TO REMOVE AND PROVIDE APPROPRIATE BREAKER DEVICE.

Comply By: 02/14/23

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12A

MN Rule 4626.0275A Store food preparation or dispensing utensils in the food with the handles above the top of the food within the container.

OBSERVED TONG HANDLES TOUCHING SAUSAGE IN LODGE SERVING ROOM. ADVISED TO COMPLY PER ABOVE RULE.

Comply By: 02/14/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

SANI DISPENSER IN LODGE SERVING ROOM IS NOT ATTACHED TO WALL AND IS HANGING INTO SINK. ADVISED TO MOUNT TO WALL AND MAINTAIN.

Comply By: 02/21/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HANDWASH SIGN OBSERVED AT SINK IN LODGE SERVICE AREA.

Comply By: 02/14/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

OBSERVED MOPS ON FLOOR AND IN BUCKET IN JANITOR CLOSET OF LODGE BUILDING. ADVISED TO COMPLY PER ABOVE RULE.

Comply By: 02/14/23

Surface and Equipment Sanitizers

Quaternary Ammonium: = 400 PPM at Degrees Fahrenheit
Location: SANI DISPENSER - SERVING ROOM
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 33 Degrees Fahrenheit - Location: FRIGIDAIRE COMMERCIAL COOLER
Violation Issued: No

Process/Item: Cold Holding/HAM
Temperature: 40 Degrees Fahrenheit - Location: TRUE PREP TOP COOLER
Violation Issued: No

Process/Item: Hot Holding/EGG
Temperature: 135 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Cold Holding/POOLED EGGS
Temperature: 39 Degrees Fahrenheit - Location: TRUE COOLER - LOWER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 182 Degrees Fahrenheit - Location: EMPURA WARMING CABINET
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	4

ESTABLISHMENT EMPLOYS THEIR OWN KITCHEN STAFF.

DISCUSSED THE FOLLOWING ON SITE WITH DIRECTOR OF CULINARY IAN CAPRAROLA AND NURSING EVALUATOR BENARD NYANGENA:
- ALL ORDERS ON REPORT.

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- REPORTABLE DISEASES.
- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM. WILL SEND APPLICATION AND FACT SHEET TO FOOD MANAGER.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY.
- DATE MARKING AND DISCARD DATE.
- PROPER STACKING ORDER TO AVOID CROSS CONTAMINATION.
- PROPER TEMPERATURES FOR HOT AND COLD HOLDING, REHEATING.
- PROPER SANITIZING LEVELS AND TEST KITS AND STRIPS ON SITE.
- PEST CONTROL.

ESTABLISHMENT DOES SAME DAY SERVICE.

LODGE DRY STORAGE ROOM OBSERVED TO HAVE VINYL BASEBOARDS AND POPCORN CEILING. ALL WERE FOUND TO BE INTACT AND IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH TIME THESE ITEMS ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, ITEMS WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1024231007 of 02/14/23.

Certified Food Protection Manager: MICHAEL I. CAPRAROLA

Certification Number: FM75769 Expires: 02/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

MICHAEL IAN CAPRAROLA
DIRECTOR OFCULINARY

Signed: _____

Sheng Yang
Public Health Sanitarian I
Freeman Building
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