Electronically Delivered

April 10, 2023

Licensee
Stonecrest
8725 Promenade Lane
Woodbury, MN 55125

RE: Project Number(s) SL25310015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 22, 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 . . ."

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

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.

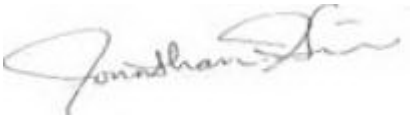
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

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

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,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-281-9796
JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25310	A. BUILDING: _____ B. WING _____	03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREST	8725 PROMENADE LANE WOODBURY, MN 55125

(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: SL25310015-0 On March 20, 2023, through March 22, 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 seventy-one residents receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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 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 following services to residents:	0 480		

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0 480	Continued From page 1 (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 March 22, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 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	0 580		

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0 580	Continued From page 2 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. This had the potential to affect all five (5) 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, 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: On March 20, 2023, at 10:30 a.m., director of nursing (DON)-B was asked to provide the licensee's quality management policy and documentation of quality management activity. On March 21, 2023, during a 1:00 p.m. interview, DON-B provided quality assurance meeting minutes from 2021, and stated the licensee did not have documentation of current quality management activity. The licensee's Quality Management Plan, dated	0 580		

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0 580	Continued From page 3 August 11, 2021, indicated the licensee would meet quarterly to evaluate the quality improvement efforts of the site. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
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 observation, interview and record	0 650		

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0 650	Continued From page 4 review, the licensee failed to ensure the employee record contained the required content for two of three employees (unlicensed personnel (ULP)-F, 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) 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). Findings include: ULP-F ULP-F was hired on November 3, 2014. ULP-F's employee record lacked evidence of an annual performance review. On March 21, 2023, at 8:00 a.m., ULP-F was observed to provide cares and medication administration to licensee clients. ULP-D ULP-D was hired on August 25, 2021. ULP-D's employee record lacked evidence of an annual performance review. On March 21, 2023, between 8:47 a.m. to 10:45 a.m., surveyor observed ULP-D perform cares, treatment, and medication administration. On March 21, 2023, at 1:00 p.m., Director of Nursing (DON)-B stated annual performance reviews had not been done for ULP-D or ULP-F.	0 650		

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0 650	Continued From page 5 A licensee's document titled 2023 PHS Annual Training indicates performance summaries and evaluations would take place annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 6 by: Based on the interview and record review, the licensee failed to comply with the frequency of inspections and load test requirements for the facility's emergency power system (permanent generator) as part of the facility's emergency disaster and preparedness plan as required under Minnesota Rules, Part 4659.0100. This had the potential to affect the current resident receiving services under the assisted living license, as well any staff and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 21, 2023, at approximately 2:30 p.m., survey staff conducted a document review and interview with the licensed assisted living director (LALD)-A, the regional maintenance director (RD)-I, and the environmental services director (ESD)-H related to system inspections and load test records of the emergency power generator as part of the facility's shelter in place emergency disaster and preparedness plan, indicated the licensee failed to provide the minimum frequency of inspections and load test requirements for the emergency power generator as outlined under NFPA 110, (as referenced under the Code of Federal Regulations, title 42, section 483.73) to ensure proper performance of the generator as follows:	0 680		

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0 680	Continued From page 7 1. Lack of monthly generator transfer switch operation and load tests. No records were provided to show the required tests. 2. Incomplete records of weekly inspections of the generator systems. On March 21, 2023, at approximately 2:30 p.m., the RD-I verbally confirmed the above findings during the document review and interview. The RD-I stated that they will work to get the correct generator system inspections and load tests as required by NFPA 110. The LALD-A and ESD-H also acknowledged the above findings. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730		

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0 730	Continued From page 8 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure records included documentation of services provided as identified in the service plan for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 730		

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0 730	Continued From page 9 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 21, 2023, at 8:45 a.m., during interview with R3, surveyor observed unlicensed personnel (ULP)-D perform bedmaking. R3 admitted to licensee for services on March 23, 2019. R3's medical record included diagnoses of hypertension (high blood pressure), chronic kidney disease, asthma, sleep apnea, Crohn's Disease and type II diabetes. R3 received assistance with blood glucose monitoring, medication administration, showers, laundry and homemaking. R3's Service Charting Form-1 Week dated February 26, through March 18, 2023, lacked documentation of services provided on the following dates: -February 26, 27, and 28 at various times of the day and for various services, and -March 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 15, 16, 17, and 18, 2023 at various time of the day for various services. On March 22, 2023, at 12:05 p.m., director of nursing (DON)-B stated the missing documentation meant that ULPs completed the cares but did not document the cares completed at the end of their shift. DON-B stated all staff	0 730		

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0 730	Continued From page 10 were trained on documentation practices at corporate medication class. The licensee's MN AL Resident Record Policy dated August 1, 2021, indicated the licensee would document that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 800		

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0 800	Continued From page 11 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 March 21, 2023, approximately from 11:00 a.m. to 1:30 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A, the regional maintenance director (RD)-I, and the environmental services director (ESD)-H. During the tour, survey staff observed the following: 1. The licensing failed to provide a lavatory for handwashing in the bathroom. The bathroom(also with door sign as spa room) on the first floor had a shower compartment used for for storage, a toilet, and a salon shampoo sink, and no lavatory was observed in the bathroom. Hand sanitizer dispenser was provided next to the shampoo sink without running water when survey staff turned the water valves to on. The RD-I confirmed the finding and agreed that they will replace the shampoo sink with a lavatory for handwashing. 2. In the memory care resident room #26, a set of knives was sitting on top of the refrigerator which posed safety concerns to memory care resident(s). The LALD-A, RD-I, and ESD-H confirmed the finding. The LALD-A presented a facility one page policy for memory care residents (no date) which stated that sharp objects and chemicals were not allowed in the memory care apartment units. 3. An unproved wye fitting with integral control valves was improperly hooked up on the threaded connection of the laundry sink faucet to serve the chemical soap dispenser and other side of the wye fitting served a hose. The installation is not in	0 800		

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0 800	Continued From page 12 compliance with state code to prevent cross-connection of chemicals to the building water supply system and need to be consulted with a local authorized contractor for code-compliant installation. The RD-I agreed to review with the manufacturer of the chemical soap dispenser for the correct water supply connection. On March 21, 2023, at approximately 2:45 p.m., during the exit interview, the LALD-A, the RD-I, and the ESD-H acknowledged the above findings. No further information was provided. PMTIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or 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.	0 810		

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	25310	A. BUILDING: _____ B. WING _____	03/22/2023

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STONECREST	8725 PROMENADE LANE WOODBURY, MN 55125

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0 810	Continued From page 13 (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 observation, record review, and interview, the licensee failed to provide the minimum frequency of employee evacuation drills and the minimum required resident training on fire safety and evacuation for residents that can self-assist in their evacuation. This has the potential to directly affect the safety of all residents receiving services, 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 March 21, 2023, from approximately 1:30 p.m. to 2:30 p.m., survey staff reviewed the	0 810		

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0 810	Continued From page 14 facility fire safety and evacuation plan and related documentation for review. At approximately 2:30 p.m., document review and interview with the licensed assisted living director (LALD)-A, the regional maintenance director (RD)-I, and the environmental services director (ESD)-H indicated the following findings: 1. The licensee lacked a record to show that required annual resident training was available that can self-assist in their own evacuation on proper actions to take in the event of a fire including movement, evacuation, or relocation. No record was available or provided for review. The ESD-H stated that the local fire department recently provided a training that included the residents, but no documentation was maintained. 2. The drill records showed insufficient number of employee fire safety and evacuation drills performed to date. Drill records provided for review were 5/3/2022 (documented as 22:55-3rd), 5/3/2022 (2:45- 2nd shift), 4/27/2022 (10:25-1st shift), 7/15/2021 (no time) and no drills were performed to date for 2023. The RD-I verbally confirmed with the findings and stated they will be working to carry out the required fire evacuation drills as required. Survey staff explained that the minimum required frequency of two fire evacuation drills for employees is twice per year per shift with at least one evacuation every other month, totally six evacuation drills per year. On March 21, 2023, at approximately 2:45 p.m., during the exit interview, the LALD-A, the RD-I, and the ESD-H acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen	0 810		

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0 810	Continued From page 15 (14) days	0 810		
0 970 SS=F	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 facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 71 residents living within the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: On March 21, 2023, at approximately 12:30 p.m.., licensed assisted living director (LALD)-A provided a blank Residency Agreement contract	0 970		

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0 970	Continued From page 16 and indicated the contract is used by licensee for all residents. On page twelve (15), the licensee's assisted living with dementia contract read that the resident "would be responsible for the costs associated with the following, caused by the acts or failure of resident, pets, resident's agents, family members, or guests, whether intentional or unintentional, and whether or not under resident's control or direction: -Any loss, property damage, or repair or service (including plumbing problems) or injury to any person, -any loss or damage caused by inappropriate use of any feature of the apartment, including as examples only and without limitation, doors or windows being left open, faucets being left open, toilet use, stoves being left on, and refrigerators being left open. " On page eighteen (18), the licensee's assisted living with dementia contract under Personal Property of Resident read "resident assumes primary responsibility for all risk for harm to or loss of any of resident's personal property." On March 22, 2023, at 11:15 a.m., LALD-A stated the licensee's assisted living with dementia contract included a waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the	01060		

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01060	Continued From page 17 facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes	01060		

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01060	Continued From page 18 a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days 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's Resident Notes dated March 11, 2023 at 10:39 a.m., indicated R2 had an emergency relocation to the hospital due to breathing difficulties. R2's Resident Notes dated March 14, 2023, at 8:59 a.m., indicated R2 would be transferred to a transitional care unit (TCU) that day around 2:00 p.m. R2's record lacked a written notice with the required statutory content was provided to resident or to the OOLTC as noted below:	01060		

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01060	Continued From page 19 In the event of an emergency relocation, the facility must provide a written notice that contained, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident had been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care (OOLTC); (4) if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and (5) a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (a) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. (b) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. On March 20, 2023, at 2:07 p.m., family member (FM)-E and FM-E stated they did not receive any written notification of the required information and had not received contact information for the	01060		

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01060	Continued From page 20 OOLTC from the facility. On March 20, 2023, at 1:49 p.m. director of nursing (DON)-B stated the family were contacted that R2 was sent to the hospital by a triage nurse and DON-B did not notify the OOLTC of the emergency relocation after four days of not returning to the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

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01500	Continued From page 21 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-D).	01500		

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01500	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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 21, 2023, between 8:47 a.m. to 10:45 a.m., surveyor observed ULP-D perform cares, treatment, and medication administration. ULP-D was hired on August 25, 2021. ULP-D's employee record lacked all required eight hours of annual training. On March 22, 2023, at 12:00 p.m., director of nursing (DON)-B stated ULP-D's record lacked the full eight hours to meet the 12-month annual training requirements. The licensee's Education & Training Policy revised on April 2022, indicated employees would receive orientation and ongoing training to assure they possessed the competencies and skill sets necessary to provide serves to meet the resident's needs safely. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01540	Continued From page 23	01540		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed the required hours of dementia care training in the required time frame 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) 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:	01540		

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01540	Continued From page 24 ULP-D was hired on August 25, 2021. ULP-D's employee record lacked the required two hours of annual dementia training. On March 22, 2023, at 12:00 p.m., human resource (HR)-J stated ULP-D was assigned two training courses titled "Alzheimer's" and "Dementia Care" on Relias, but ULP-D did not complete the assigned courses. The licensee's Dementia Training policy dated August 1, 2021, indicated all staff would receive training on topics related to dementia care for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640		

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01640	Continued From page 25 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the facility to document agreement on the services to be provided for one of five residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted on April 1, 2021. R4's diagnoses included asthma, dementia, and glaucoma. R4's Service Plan-Attachment E to Residency Agreement signed by a registered nurse (RN) on November 9, 2022, lacked a signature or authentication by the resident and/or designated representative.	01640		

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STONECREST	8725 PROMENADE LANE WOODBURY, MN 55125

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01640	Continued From page 26 On March 21, 2023, at 11:37 a.m., house manager (HM)-G stated the service agreement was not sent out to the family and verified the lack of authentication or signature from the resident and/or designated representative. The licensee's MN AL Service Plan Policy dated August 1, 2021 indicated service plans and any revisions to service plans would have a signature or other authentication by the licensee and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the licensee. No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		
01890 SS=D	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 review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of five residents (R5, R4).	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25310	A. BUILDING: _____ B. WING _____	03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREST	8725 PROMENADE LANE WOODBURY, MN 55125

(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
01890	Continued From page 27 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 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: ORIGINAL PRESCRIPTION LABELS R5's service plan dated February 20, 2023, indicated R5 received services to include medication management. On March 21, 2023, at 8:00 a.m. unlicensed personnel (ULP)-F was observed assisting R5 with medication administration including Fluticasone nasal spray (nasal corticosteroid). R5's opened Fluticasone nasal spray lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. During an interview on March 21, 2023, registered nurse (RN)-C indicated unlicensed personnel should notify the nurse if a medication label is missing or unreadable. The licensee's MN AL Medication Management Policy, dated August 5, 2021, indicates medications would be in the original pharmacy-dispensed container with a proper label and directions.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25310	A. BUILDING: _____ B. WING _____	03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREST	8725 PROMENADE LANE WOODBURY, MN 55125

(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
01890	Continued From page 28 TIME SENSITIVE MEDICATIONS R4 received medication administration. On March 21, 2023, at 9:00 a.m., ULP-D was observed to administer medications to R4. During administration, surveyor observed Vitamin D3 1000 unit tablets in each blister pack (medications are held in individual packs and ULP will punch the medication out through sealed foil) and loratadine (Claritin) 10 milligram (mg) tablets in each blister pack. Neither blister packs were observed to have expiration dates.. On March 21, 2023, at 9:15 a.m., registered nurse (RN)-K stated the expiration dates were missing from both blister packs and were usually written on the back of the pack. The licensee's MN AL Medication Management Policy updated on August 5, 2021, indicated the nurse would verify the accuracy of blister packs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *03/22/23*
Time: 12:52:58
Report: 1023231054

Food and Beverage Establishment Inspection Report

Location:
Stonecrest
8725 Promenade Lane
Woodbury, MN55125
Washington County, 82

Establishment Info:
ID #: 0038035
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6512643200
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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

HIGH TEMP DISH MACHINE IN USE WITHOUT IRREVERSIBLE THERMOMETER. OBTAIN AND USE THIS DEVICE TO ENSURE EFFECTIVE SANITIZATION.

Comply By: 03/22/23

4-200 Equipment Design and Construction

4-201.11AMN

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

DOMESTIC TYPE REFRIGERATOR IN USE FOR COMMERCIAL FOOD SERVICE IN MEMORY CARE SERVICE AREA. REPLACE WITH COMMERCIAL GRADE EQUIPMENT.

Comply By: 03/22/23

Surface and Equipment Sanitizers

S&S: = 700PPM at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

S&S: = 700PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Food and Beverage Establishment Inspection Report

Hot Water: = at 165 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/CUT TOMATO
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Cold Hold/SOUP
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/YOGURT
Temperature: 41 Degrees Fahrenheit - Location: MEMORY CARE COOLER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION. FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD. THIS FACILITY CONSISTS OF A FULL SERVICE MAIN KITCHEN AREA WITH TYPE I HOOD/ANSUL AND PREP SINK. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FOOD REHEATING METHODS
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

Food and Beverage Establishment Inspection Report

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 1023231054 of 03/22/23.

Certified Food Protection Manager: JACQUELINE LEUER

Certification Number: 86278 Expires: 06/15/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

JACQUELINE LEUER
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us