DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 7, 2022

Administrator
Twin Cities Assisted Living
2814 Colfax Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL32070015

Dear Administrator:

On September 2, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 19, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

August 5, 2022

Administrator
Twin Cities Assisted Living
2814 Colfax Avenue North
Minneapolis, MN 55411

RE: Project Number(s) SL32070015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 19, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements = $3,000
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500

The total amount you are assessed is $3,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general Free from Maltreatment reconsideration

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

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: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES ASSISTED LIVING	2814 COLFAX AVENUE NORTH MINNEAPOLIS, MN 55411

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32070015 On July 18 through July 19, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 6 residents, all of whom received services under the provider's Assisted Living license. On July 19, 2022, the immediacy of correction order 0470 has been removed, however non-compliance remains at a scope and level of G.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 430 SS=D	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 1 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) with the required content for 1 of 1 resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	0 430		

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0 430	Continued From page 2 R1 was admitted January 3, 2017, and began receiving Assisted Living services August 1, 2021. R1's Statement of Homecare Individual Service Plan, signed by R1's representative on January 4, 2017, indicated R1 received assistance with medication administration, bathing, activities of daily living (ADLs), laundry, housekeeping, dressing, and grooming, transfers, and toileting. R1's record lacked documentation a UDALSA had been provided, to include: - a disclosure of the categories of Assisted Living licenses available and the category of license held by the facility; - a written checklist listing all services permitted under the facility's license identifying all services the facility offered to provide under the assisted living facility contract, and identifying all services allowed under the license the facility did not provide; and -an oral explanation of the services offered under the contract. On July 19, 2022, at 2:52 p.m. licensed assisted living director (LALD)-B verified R1's record did not contain a UDALSA. LALD-B stated R1 had not been previously provided a UDALSA. The LALD further stated she had created a new resident contract and packet which would include the UDALSA going forward and provided a blank copy to surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		

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0 450	Continued From page 3	0 450		
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide current Minnesota Assisted Living Bill of Rights (BOR) for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted January 3, 2017, and began receiving assisted living services August 1, 2021. R1's record included a Statement of Homecare Individual Service Plan, signed by R1's	0 450		

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0 450	Continued From page 4 representative on January 4, 2017, indicating R1 received assistance with medication administration, bathing, activities of daily living (ADLs), laundry, housekeeping, dressing, and grooming, transfers, and toileting. R1's records lacked documentation indicating the current Assisted Living BOR was provided. On July 18, 2022, at 2:03 p.m., licensed assisted living director (LALD)-B stated R1 did not yet have an updated assisted living contract which would include the updated BOR. LALD-B provided a new blank admission contract packet including the new BOR under addendum F. LALD-B further stated she would use the new documents with current residents and new admissions going forward. The licensee's undated Assisted Living Bill of Rights policy indicated, "The designated admitting professional shall provide the client with a written notice of the Assisted Living Bill of Rights, including their right to complain and the person to contact with complaints at the time of admission. In the event that the client is incompetent, the Assisted Living Bill of Rights shall be devolved with the client's legal guardian. The reason the client is unable to acknowledge receipt of the Assisted Living Bill of Rights shall be documented." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460		

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0 460	Continued From page 5 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 460		

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0 460	Continued From page 6 On July 18, 2022, at 10:49 a.m., during the entrance conference, the licensed assisted living director (LALD)-B and assistant to the director (AD)-C acknowledged the licensee lacked a system for residents to request assistance when needed, 24 hours a day. LALD-B stated staff were available to the residents at all times and residents could verbally summon assistance. LALD-B stated residents were located on the main floor and second floor and staff would hear a resident if they yelled or fell. On July 19, 2022, at 2:52 p.m., LALD-B stated she ordered a pendant system on July 19, 2022, which would be implemented upon arrival. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week,	0 470		

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0 470	Continued From page 7 who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure sufficient staffing to meet the needs of one of one resident (R1), who required two person transfers with a mechanical lift, with record reviewed. This resulted in an immediate correction order on July 19, 2022, at 9:45 a.m. Further, the licensee failed to develop a staffing plan, to be reviewed at least every six (6) months, to ensure staff were able to meet resident needs. 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 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: The licensee lacked sufficient staffing to meet R1's needs on a 24-hour basis as required by	0 470		

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0 470	Continued From page 8 R1's assessment and service plan. On July 18, 2022, at 10:50 a.m., during the entrance conference, licensed assisted living director (LALD)-B stated there was no written staffing plan developed. LALD-B further stated they typically staff one unlicensed personnel (ULP) during each shift, (identified as 7:00 a.m.-3:00 p.m., 3:00-11:00 p.m., and 11:00 p.m.-7:00 a.m.) and assistant director (AD)-C was present Monday-Friday approximately 8:00 a.m.-5:00 p.m. R1's 90-Day Home Care Assessment dated May 10, 2022, indicated R1 used a Hoyer lift (full body mechanical lift). R1's Care Plan reviewed May 10, 2022, indicated R1 required daily assistance of two staff for transfers with Hoyer lift. The care plan further indicated R1 received 24-hour staff assistance with Hoyer lift. On July 18, 2022, at 2:16 p.m., ULP-D stated R1 was transferred out of bed "at least twice a week." ULP-D further stated they used two staff for transfers, and would only transfer R1 out of bed while two staff were present. On July 18, 2022, at 3:15 p.m., during a tour of the facility with AD-C, the licensee's weekly staff schedule was observed to be posted. On July 18, 2022, at 3:20 p.m., ULP-E stated he usually worked the 3:00-11:00 p.m. shift alone. ULP-E further stated he has assisted to get R1 out of bed, but typically does not do that on his shift. On July 18, 2022, at 3:22 p.m., AD-C verified the	0 470		

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0 470	Continued From page 9 3:00-11:00 p.m. shift was staffed by one ULP after her shift ended. AD-C further verified additional staff names that appeared on the schedule, one for the 3:00-11:00 p.m. shift and one for the 11:00 p.m.-7:00 a.m. shift, were scheduled for another facility. The licensee's posted Employee Schedules from July 17, 2022, to July 23, 2022, indicated the following: -Sunday, July 17, 2022; two staff for each shift (identified as one staff at each facility, per shift): 7:00 a.m.-3:00 p.m., 3:00-11:00 p.m., and 11:00 p.m.-7:00 a.m. -Monday, July 18, 2022; two staff for each shift (identified as one staff at each facility, per shift): 7:00 a.m.-3:00 p.m., 3:00-11:00 p.m., and 11:00 p.m.-7:00 a.m., and AD-C scheduled 9:00 a.m.-5:00 p.m. -Tuesday, July 19, 2022; two staff for each shift (identified as one staff at each facility, per shift): 7:00 a.m.-3:00 p.m., 3:00-11:00 p.m., and 11:00 p.m.-7:00 a.m., and AD-C scheduled 9:00 a.m.-5:00 p.m. -Wednesday, July 20, 2022; two staff for each shift (identified as one staff at each facility, per shift): 7:00 a.m.-3:00 p.m., 3:00-11:00 p.m., and 11:00 p.m.-7:00 a.m., and AD-C scheduled 9:00 a.m.-5:00 p.m. -Thursday, July 21, 2022; two staff for each shift (identified as one staff at each facility, per shift): 7:00 a.m.-3:00 p.m., 3:00-11:00 p.m., and 11:00 p.m.-7:00 a.m., and AD-C scheduled 9:00 a.m.-5:00 p.m. -Friday, July 22, 2022; two staff for each shift (identified as one staff at each facility, per shift): 7:00 a.m.-3:00 p.m., 3:00-11:00 p.m., and 11:00 p.m.-7:00 a.m., and AD-C scheduled 9:00 a.m.-5:00 p.m. -Saturday, July 23, 2022; two staff for each shift	0 470		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES ASSISTED LIVING	2814 COLFAX AVENUE NORTH MINNEAPOLIS, MN 55411

(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
0 470	Continued From page 10 (identified as one staff at each facility, per shift): 7:00 a.m.-3:00 p.m., 3:00-11:00 p.m., and 11:00 p.m.-7:00 a.m. On July 18, 2022, at 3:26 p.m., LALD-B stated they used two staff to transfer R1 with the Hoyer lift. AD-C added R1 was assisted with transfer out of bed approximately four times per week for showers, appointments and activities. The licensee's undated Staffing Policy indicated the staffing plan must be evaluated at least twice per year and include sufficient staffing at all times to meet the scheduled and reasonably foreseeable needs of each resident. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE Immediacy was removed as confirmed by evaluation supervisor correspondence between licensee and supervisor on July 19, 2022, however noncompliance remains at a scope and severity of G.	0 470		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:	0 480		

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0 480	Continued From page 11 (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 had the potential to affect all residents of 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) 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 July 18, 2022, 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	0 510		

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0 510	Continued From page 12	0 510		

complies with accepted health care, medical, and nursing standards for infection control.
(b)The facility's infection control program must be 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 accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure appropriate personal protective equipment was worn in the facility and while providing cares. This had the potential to affect all six (6) 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:

COVID SCREENING:
On July 18, 2022, at 10:15 a.m., upon entering the facility unlicensed personnel (ULP)-D did a

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0 510	Continued From page 13 partial screening of both surveyors. ULP-D took a temperature reading but failed to screen for additional symptoms or exposure to COVID-19. On July 19, 2022, at 8:36 a.m., a surveyor knocked and entered the facility. Staff did not approach the surveyor for COVID sign and symptom screening. On July 19, 2022, at 8:45 a.m., a second surveyor knocked and called out before entering the facility. No staff were available, so the surveyor entered and sat at the designated work space in the dining area. The surveyor was not screened for COVID signs and symptoms upon entry. On July 19, at 8:55 a.m., the assistant to the director (AD)-C entered the dining area, acknowledged the surveyors, conversed with the surveyors briefly, then left the dining area. The surveyors were not screened for COVID signs and symptoms. On July 19, 2022, licensed assisted living director (LALD)-B provided COVID-19 screening logs for July printed on July 19, 2022. The screening log included screening documentation for ULPs that worked each shift. The screening log lacked screening documentation for LALD-B, AD-C, and visitors including the survey team and outside contractor (OC)-F, who was observed to be present in the facility. On July 19, 2022, during a 12:37 p.m. interview, registered nurse (RN)-A stated staff screened themselves for signs and symptoms of COVID-19 and visitors should have their temperature checked and sign in upon entry to the facility. Centers for Disease Control and Prevention	0 510		

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0 510	Continued From page 14 (CDC) Interim infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated September 10, 2021 indicated facilities should establish a process to identify anyone entering the facility, regardless of vaccination status, who has a positive viral test for SARS-CoV-2, symptoms of COVID-19, or who meets criteria for quarantine (been in close contact (within 6 feet of someone for a cumulative total of 15 minutes or more over a 24-hour period) with someone who has COVID-19). Options include individual screening on arrival at the facility, or an electronic monitoring system in which individuals can self-report any of the above before entering the facility. COVID PPE: On July 18, 2022, at 11:35 a.m., ULP-D was observed to assist R1 with blood glucose monitoring. ULP-D wore a surgical type-facemask, but lacked eye protection while checking R1's blood glucose. On July 18, 2022, at 11:52 a.m., ULP-D stated she wore a mask while in the facility. ULP-D further stated she would wear eye protection if a resident was showing COVID symptoms, or to clean up a mess. ULP-D stated she did not wear eye protection when giving medications. On July 18, during a continuous observation from 2:14 p.m., to 2:55 p.m., ULP-D was observed to be wearing a facemask on her chin, exposing both her mouth and nose. ULP-D was further observed to provide assistance with activities of daily living (ADLs) for R1, while wearing a facemask on her chin and not wearing eye protection.	0 510		

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0 510	Continued From page 15 On July 18, 2022, at 2:53 p.m., ULP-D and ULP-E were observed in the kitchen area of the facility discussing dinner preparation. Both staff were observed not wearing a facemask. On July 18, 2022, at 3:25 p.m. ULP-E observed without a mask or eye protection. On July 19, 2022, at 8:45 a.m., ULP-D was observed without a mask or eye protection as she prepared medications for resident (R1). On July 19, 2022, during a 12:37 p.m. interview, RN-A stated she had not instructed staff to wear a mask in the facility anymore. RN-A stated she was not aware masks and eye protection were still required. On July 19, 2022, at 3:03 p.m., LALD-B stated she was not aware of the COVID-19 personal protective equipment (PPE) requirements. LALD-B was shown the county transmission rate for Hennepin County and the PPE requirements grid, dated April 7, 2022, and agreed masks and eye protection should be worn. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated April 7, 2022, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well-fitting facemask and eye protection. In addition, it instructed HCW with no face-to-face contact with residents to wear a medical-grade well-fitting facemask. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source	0 510		

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0 510	Continued From page 16 Control Grids - for congregate care settings, by community transmission level", dated July 18 and July 19, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection. The CDC COVID Data Tracker on July 18 and July 19, 2022, indicated Hennepin County, MN (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents. HAND HYGIENE: On July 18, 2022, during a 12:27 p.m., treatment and medication administration observation, the following observations were made: -at 12:27 p.m. ULP-D, while performing hand hygiene at the kitchen sink, turned on the faucet, added soap to hands, and rubbed hands together under the running water for 10 seconds, then donned gloves. -ULP-D assisted R2 with blood glucose monitoring, then insulin and oral medication administration, doffed gloves, and performed hand hygiene under running water for 9 seconds. -ULP-D documented in the medication administration record, then retrieved additional medications for R2, performed hand hygiene under running water for 5 seconds, then donned gloves before returning to R2's room to administer an additional insulin injection. On July 19, 2022, at 2:26 p.m., ULP-D was observed to provide assistance with ADLs for R1.	0 510		

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0 510	Continued From page 17 ULP-D wore gloves while providing assistance with dressing, grooming, and incontinence care. ULP-D was observed to doff gloves. ULP-D removed garbage from R1's room, deposited garbage bag in garage, then loaded dirty dishes into the dishwasher and mopped the kitchen floor. No hand hygiene was observed. On July 19, 2022, during a 12:37 p.m. interview, RN-A stated infection control training was provided when staff were hired and annually. RN-A further stated staff were trained to perform hand hygiene for 30 seconds or to use hand sanitizer. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, and record	0 550		

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0 550	Continued From page 18 review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all six (6) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked a posting in a common area of the facility of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. On July 18, at 10:35 a.m., during the entrance conference, licensed assisted living director (LALD)-B and assistant director (AD)-C stated their grievance/complaint and procedure were not posted in the facility. On July 18, at 11:24 a.m., during a tour of the facility, the surveyors verified a grievance/complaint procedure was not posted in the facility. The licensee's Complaint and Investigation Process policy, undated, indicated the "clients of [licensee] are provided with written information about how to address their concerns and	0 550		

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0 550	Continued From page 19 questions related to their care." The policy did not address posting the grievance procedure in a common area of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 580 SS=C	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for 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 ongoing quality management activities relevant to the size and services provided by the assisted living provider. This had the potential to affect all six (6) 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	0 580		

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0 580	Continued From page 20 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: On July 18, 2022, at 11:19 a.m., during the entrance conference, the licensee's quality management plan and meeting schedule was requested. The licensed assisted living director (LALD)-B stated they had quality management meetings, but they were not documented. LALD-B further stated they do not have a current documented quality management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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	0 660		

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0 660	Continued From page 21 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 one of two employees (registered nurse (RN)-A), and TB infection control training for two of two employees (RN-A, unlicensed personnel (ULP)-D) with records reviewed. Further, the facility failed to maintain a current Facility TB Risk Assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB RISK ASSESSMENT The Facility TB Risk Assessment, dated July 10, 2018, indicated the facility was at a low risk for TB transmission. On July 18, 2022, at 10:35 a.m., during the entrance conference, licensed assisted living director (LALD)-B acknowledged the Facility TB Risk Assessment had not been updated. ULP-D	0 660		

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0 660	Continued From page 22 ULP-D was hired September 20, 2019, and provided direct care services for the residents of the facility. ULP-D's employee record included documentation of orientation completed September 20, 2019, and training completed September 27, 2019, but both lacked content to include TB infection control training. RN-A RN-A was hired July 22, 2021, and provided direct care and supervisory services for the licensee. RN-A's record lacked documentation of TB education, baseline testing and symptom and history screening completed upon hire. On July 18, 2022, at 2:03 p.m., licensed assisted living director LALD-B stated she remembered RN-A had a chest xray, but confirmed the documentation was not available in RN-A's employee record. On July 19, 2022, at 12:37 p.m., RN-A stated she had a TB blood test when she was initially hired. RN-A stated she resigned and was later rehired by the licensee. RN-A further stated she was not screened for TB upon rehire and did not participate in any formal orientation including TB training. RN-A indicated she was not aware if TB training was included in new employee orientation. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition,	0 660		

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0 660	Continued From page 23 baseline screening for all health care workers (HCW) included a history and symptom screen and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. According to the regulations, if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's Tuberculosis Screening policy, undated, indicated, "For all employees or contract personnel providing direct client care, there shall be evidence of baseline TB screening consisting of two components: a. Assessing for current symptoms of active TB disease, (see attached screening tool) and b. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test." The policy further indicated, "All staff will receive education and training about TB. Training will be conducted prior to initial assignment and annually thereafter." 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	0 680		

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(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
0 680	Continued From page 24 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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all six (6) 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 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:	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES ASSISTED LIVING	2814 COLFAX AVENUE NORTH MINNEAPOLIS, MN 55411

(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
0 680	Continued From page 25 The licensee converted to an Assisted Living license August 1, 2021. On July 19, 2022, at 11:00 a.m., the licensee's EP plan, dated July 18, 2022, was reviewed and noted to lack information and customization to the facility and resident-specific individualization. The licensee-provided EP plan lacked individualized emergency procedures to include the following: - written policies: - documented risk assessment; - arrangments/contracts to re-establish utility services; - a risk assessment considering all hazards that may impact all or a portion of the facility; - a risk assessment considering emerging infectious diseases (EIDs); - categorize the various probable risks/hazards by likelihood of occurence; - an assessment of the at risk population's needs; - a process for emergency preparedness cooperation with state and local EP officials/organizations; - strategies for addressing facility and community based risks (evacuation plan, staffing shortage, back-up plans); - a tracking system used to document locations of residents and staff; - missing resident plan; - the medical record documentation system to preserve resident information; - means of releasing and providing resident information in the event of an evacuation; - identify at risk population needs; - identify which staff would assume specific roles and in another staff members absense; - handling and use of volunteers;	0 680		

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0 680	Continued From page 26 - plan to address food, water, and pharmaceutical supplies; - alternate sources of energy to maintain safe tempurature, sanitation, emergency lighting, fire detection, sewage; - include a process for cooperating and collaboration with local tribal, regional, state and federal EP to maintain integrated response; - plan for evacuation; - EP training and and testing program; - conducting exercises to test the EP at least twice per year; - arrangments and agreements with other facilities; - how the facility would operate under an 1135 waiver; - a written communication plan that included: - names and contact information for staff, resident physicians, other facilities; and - a method of sharing information and medical documentation for residents. - contact information for Federal, State, tribal, regional and local EP staff - State Licensing and Certification Agency - Minnesota Office of Ombudsman - other sources of assistance On July 19, 2022, at 3:03 p.m., licensed assisted living director (LALD)-B acknowledged the EP plan needs improvement. LALD-B indicated she was familiar with "Appendix Z", but expressed it was difficult to understand all the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 780	Continued From page 27	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in 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 inside and outside of the sleeping rooms, and ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 780		

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0 780	Continued From page 28 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 issued at a widespread scope(when problems are pervasive or present a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On July 18, 2022, from approximately 12:00 to 2:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-B. During the facility tour, survey staff observed that 4 upstairs and 3 downstairs sleeping rooms lacked interconnected smoke alarms. It was also observed that each level of the dwelling unit lacked interconnected smoke alarms. LALD-B verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 800		

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0 800	Continued From page 29 by: Based on observation and interview, the licensee failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope(when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On July 18, 2022, from approximately 12:00 p.m. to 2:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-B. During the facility tour, survey staff observed the following: 1. 1st floor bathroom ceiling fan missing cover; 2. 1st floor bathroom light fixture hanging by wires; 3. 1st floor bedroom #2 door missing wood frame (below door knob); 4. 1st floor bedroom #1 vinyl floor torn and in disrepair. LALD-B verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one(21) days	0 800		

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0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced	0 900		

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0 900	Continued From page 31 by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: The facility converted to an Assisted Living license on August 1, 2021. R1's record lacked a current assisted living contract. On July 18, 2022, at approximately 1:45 p.m., licensed assisted living director (LALD)-B verified R1 did not have a signed assisted living contract in his record. On July 19, 2022, at 2:52 p.m., LALD-B stated she had created a new resident contract and new admit packet. LALD-B provided a copy of the contract she would be using going forward. The licensee's Assisted Living Contract policy, undated, indicated, "An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract."	0 900		

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0 900	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced	0 950		

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0 950	Continued From page 33 by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: The licensee converted to an assisted living license on August 1, 2021. R1 was admitted January 3, 2017, and began receiving services under the Assisted Living license August 1, 2021. R1's record lacked documentation indicating R1 was given the opportunity to designate a representative for certain purposes. On July 19, 2022, at 2:52 p.m., licensed assisted living director (LALD)-A verified R1 was not provided a form offering the right to designate a representative. LALD-B stated she had created a new resident contract and new admit packet that includes the required form. The licensee's Right to Designate a Representative policy, undated, indicated, "Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated	0 950		

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0 950	Continued From page 34 representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES"." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced	01440		

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01440	Continued From page 35 by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one unlicensed staff (unlicensed personnel (ULP)-D) with employee record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: ULP-D was hired September 20, 2019, and provided direct care services for the residents of the facility. R1's medication administration record for July 2022 indicated ULP-D assisted R1 with blood glucose monitoring and medication administration on the following dates: July 7-14, 16, and 18, 2022 ULP-D's employee record included documentation of blood glucose testing and medication administration training and competency completed September 27, 2019, but lacked documentation the RN completed a 30-day supervision. On July 19, 2022, during a 12:37 p.m. interview, registered nurse RN-A stated she was	01440		

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01440	Continued From page 36 responsible for 30-day supervision of staff. RN-A stated she did frequently observe staff, but did not document it. The licensee's Supervision of Unlicensed Personnel policy, undated, indicated, "The direct supervision of staff performing delegated tasks must be provided within 30 days after the individual begins working for the home care provider and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed orientation to assisted living facility licensing requirements and regulations before providing services for two of two employees (registered nurse (RN)-A, and unlicensed personnel (ULP)-D) with employee records	01460		

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01460	Continued From page 37 reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee converted to an Assisted Living license on August 1, 2021 RN-A was hired July 22, 2021, and provided direct care and supervisory services for the licensee. ULP-D was hired September 20, 2019, and provided direct care services for the residents of the facility. RN-A and ULP-D's employee records both lacked documentation that orientation to Assisted Living requirements was provided to include: - Overview of Assisted Living statutes; - Handling of emergencies and use of emergency services; - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01460		

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01460	Continued From page 38 other relevant advocacy services; - Review of types of Assisted Living services the employee will provide and provider's scope of license; and - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 18, 2022, at 2:03 p.m., licensed assisted living director (LALD)-B confirmed there were no orientation records available for RN-A. On July 19, 2022, at 12:37 p.m., RN-A stated she had resigned and was later rehired by the licensee. RN-A further stated she did not participate in any formal orientation upon rehire. RN-A indicated she was not aware if updated orientation was provided to employees. The licensee's Orientation and Annual Training Requirements policy, undated, indicated, "Agency will provide orientation and training to all staff at the time of hire and as needed to meet state guidelines and quality standards. Orientation will be provided to staff before they provide Assisted Living services to clients. Orientation will be completed once for each staff person and will not be transferable to another Assisted Living provider." The policy did not reflect the current Assisted Living Orientation requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES ASSISTED LIVING	2814 COLFAX AVENUE NORTH MINNEAPOLIS, MN 55411

(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
01530	Continued From page 39 (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial 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 the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for two of two employees (registered nurse (RN)-A, and unlicensed personnel (ULP)-D) with employee records reviewed. This had the potential to affect all six (6) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES ASSISTED LIVING	2814 COLFAX AVENUE NORTH MINNEAPOLIS, MN 55411

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01530	Continued From page 40 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: The licensee converted to an Assisted Living license on August 1, 2021 RN-A was hired July 22, 2021, and provided direct care and supervisory services for the licensee. ULP-D was hired September 20, 2019, and provided direct care services for the residents of the facility. RN-A and ULP-D's employee records both lacked documentation RN-A and ULP-D completed the required hours of dementia care training in the required topics. On July 18, 2022, at 2:03 p.m., licensed assisted living director (LALD)-B stated dementia care training records were not available for RN-A. On July 18, 2022, at 2:38 p.m., ULP-D stated she recalled having some dementia care training upon hire, but not lately. ULP-D indicated she could use updated training. On July 19, 2022, during a 12:37 p.m. interview, RN-A stated she did not have dementia care training. RN-A further stated she was aware of the requirement, and had previously discussed the need for dementia care training with LALD-B.	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
01530	Continued From page 41 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered per providers orders for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 42 The findings include: R2 was admitted July 13, 2021, and received services to include medication management and blood glucose monitoring. R2's medication administration record (MAR) for July 2022, indicated R2 received Insulin Aspart Flexpen 3 milliliters (ml), inject 3 units plus sliding scale three times daily. R2's MAR further indicated ULP-D administered the medication July 7-14, 16, and 18, 2022. R2's record included a signed order, dated March 11, 2022, that indicated, "insulin aspart (U-100) 100 unit/ml (3 ml) subcutaneous pen (NovolOG)," and "Inject 3 Units under the skin three times a day with meals. Sliding Sca1e: <140 no insulin, 140-189 = 1 unit, 190-239 = 2 units, 240-289 = 3 units, 290-339 = 4 units, >340 and over = 5 units, >400 call RN. Max 24 units per day". On July 18, 2022, at 12:28 p.m., the surveyor observed ULP-D assist R2 with blood glucose check and medication administration. ULP-D gathered medications, including the insulin aspart, and blood glucose meter and proceeded to R2's room. ULP-D checked R2's blood glucose level with the meter and verbalized the blood glucose level was "195". ULP-D initially verbalized R2 required 2 units of insulin per the sliding scale, primed the pen with 1 unit of insulin, dialed the pen to 4 units (3 units baseline, plus 1 for the sliding scale), and stated, "I think she gets one extra...140-190, and over 200 she gets 2 units". ULP-D administered 4 units of insulin to R2. ULP-D returned to the MAR located on the computer on the first floor, verbalized the blood glucose level was "189" and accessed the history on the blood glucose meter to verify the reading.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN CITIES ASSISTED LIVING	2814 COLFAX AVENUE NORTH MINNEAPOLIS, MN 55411

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01760	Continued From page 43 The surveyor observed the blood glucose meter to display "195". ULP-D stated that she administered the correct amount of insulin. The surveyor requested ULP-D access the history on the blood glucose meter again, and verified with ULP-D the meter displayed "195". ULP-D verbally acknowledged the error and stated she would need to administer one more unit of insulin to R2. On July 19, 2022, during a 12:37 p.m. interview, registered nurse (RN)-A stated she provided the training on blood glucose testing and medication administration. RN-A verified staff are trained to prime an insulin pen with 2 units prior to administration. RN-A further stated staff was expected to know the sliding scale for a resident's insulin, but acknowledged the process could be improved by having the information available at the point of care. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and ensure only authorized personnel had	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32070	A. BUILDING: _____ B. WING _____	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 44	01880		

access. Further, the licensee failed to ensure medications were stored according to manufacturer directions, and dispose of expired medications. This had the potential to affect all six (6) residents in 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, 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 July 18, 2022, at 11:35 a.m., during a medication administration observation, unlicensed personnel (ULP)-D was observed to remove a Novolog Flexpen (insulin aspart, a fast-acting insulin) 100 unit (u)/milliliter (ml) insulin injection pen for R1 from the medication storage cabinet. The insulin pen was observed to be lacking a date to indicate when the pen was first used. ULP-D and licensed assisted living director (LALD)-B verified the pen lacked an opened date.

The manufacturer instructions on the box for Novolog Flexpen were observed to indicate the insulin injection pens should be used within 28 days after they are opened.

On July 19, 2022, at 11:24 a.m., medication storage was reviewed. Medications were observed to be kept in locked boxes in the main refrigerator. The refrigerator was not locked. The refrigerator temperature was observed to be

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01880	Continued From page 45 42 degrees Fahrenheit (F). No temperature log was observed to document daily temperature readings. The following medications were observed in the refrigerator: R1 -haloperidol (an antipsychotic) 2milligrams (mg)/ml - expired February 2, 2022; -haloperidol 2mg/ml - expired March 30, 2022; -lorazepam (an antianxiety medication) 2mg/ml - expired March 23, 2022; -3 pens Lantus Solostar (insulin glargine, a long-acting insulin) 100 u/ml; -6 pens Novolog Flexpen 100u/ml; -1 unopened box of Lantus Solostar (5 pens). R2 -10 pens Lantus Solostar 100 u/ml; -4 pens insulin aspart flexpen 100u/ml. The manufacturer instructions on the box for Lantus Solostar pens was observed to indicate unopened pens should be stored in a refrigerator 36-46 degrees F. The manufacturer instructions on the box for Novolog Flexpen and insulin aspart flexpen were observed to indicate the pens should be kept in a refrigerator at 36-46 degrees F until first use. On July 19, 2022, at 11:34 a.m., ULP-D verified the refrigerator is kept unlocked, and medications are kept under single locks in boxes in the refrigerator. ULP-D further stated she reviewed the refrigerator temperature every day, but did not document the temperatures. On July 19, 2022, during a 12:37 p.m. interview, registered nurse (RN)-A stated she looked over	01880		

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01880	Continued From page 46 the stored medications at least every couple weeks. RN-A acknowledged she did not always look at the medications stored in the refrigerator. RN-A further stated she would expect controlled medications such as haloperidol and lorazepam to be stored under double lock. RN-A indicated the medications were previously stored in a locked refrigerator in the nursing office, but it was moved to the main refrigerator to be accessible to staff on the evening and night shift when the office was locked. RN-A acknowledged she had not educated staff on dating insulin pens when first used. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *07/18/22*
Time: 01:30:11
Report: 1029221219

Food and Beverage Establishment Inspection Report

Location:
Twin Cities Assisted Living
2814 Colfax Avenue North
Minneapolis, MN55411
Hennepin County, 27

Establishment Info:
ID #: 0038633
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124408001
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers
3-304.11A ***** Priority 1 *****

MN Rule 4626.0270A Do not allow food to contact surfaces of equipment and utensils that are not cleaned and sanitized.

DISHWASHER NOT ABLE TO ADEQUATELY SANITIZE. INSTRUCTED TO USE A LARGE CONTAINER WITH SANITIZER SOLUTION TO SANITIZE ALL DISHES AND UTENSILS.

Comply By: 07/18/22

3-500C Microbial Control: date marking
3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

NO DATE MARKING ON OPEN DELI MEATS.

Comply By: 07/18/22

2-100 Supervision
2-102.12AMN

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

CFPM NOT EMPLOYED BY FACILITY,

Comply By: 08/31/22

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

HANDWASHING SIGN NOT PRESENT AT KITCHEN HANDWASHING SINK AREA.

Comply By: 07/25/22

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH AN HRD SURVEY AT TWIN CITIES ASSISTED LIVING LOCATED AT 2814 COLFAX AVENUE NORTH, MINNEAPOLIS, MN 55411.

THE INSPECTION WAS CONDUCTED IN THE PRESENCE OF BRENDA CONNELL, PCA; STEPHANIE NEAL, ASSISTANT TO THE DIRECTOR; AND AMBER KARY, DIRECTOR. ALL ISSUES WERE DISCUSSED WITH STEPHANIE AND/OR AMBER DURING AND AFTER THE INSPECTION. EMPLOYEE ILLNESS REPORTING AND EXCLUSION PROCEDURES WERE ALSO DISCUSSED. ALL ISSUES WERE COMMUNICATED TO LEAD HRD SURVEYOR AND HFE-NURSE EVALUATOR II, RENEE L. ANDERSON, BSN, RN-BC, FOLLOWING THE INSPECTION.

KITCHEN FLOORS ARE TILE, AND KITCHEN CEILINGS ARE SMOOTH AND PAINTED. KITCHEN HAS LAMINATE COUNTERTOPS, AND CABINETRY/SHELVING IS WOOD. WOOD SHELVING IS PROTECTED BY WHITE MATERIAL, BUT THAT MATERIAL HAS WORN AWAY IN SEVERAL AREAS, LEAVING AN EXPOSED AND ABSORBENT WOOD SURFACE. AREAS OF THE WALLS AND SOME OF THE CABINETRIES ARE DAMAGED. DISHWASHER IS INCORRECTLY FREESTANDING AND IS NOT HOUSED UNDER/IN THE COUNTER AREA. KITCHEN IS NOT IN GOOD CONDITION.

THE IMPORTANCE OF ADEQUATE SANITIZING AND DATE MARKING WAS EMPHASIZED. I INSTRUCTED THE OPERATORS TO IMMEDIATELY ADDRESS THEIR LACK OF ABILITY TO SANITIZE DISHES AND UTENSILS BY SETTING UP A CONTAINER WITH A SANITIZER SOLUTION.

DISHWASHER IS NOT IN ACCORDANCE WITH NSF INTERNATIONAL NSF/ANSI STANDARD 184 FOR RESIDENTIAL DISHWASHERS. A DISHWASHER THAT IS IN ACCORDANCE WITH THE NSF/ANSI STANDARD 184 WILL BE REQUIRED OR AN ALTERNATE METHOD OF SANITIZING WILL NEED TO BE IMPLEMENTED.

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 1029221219 of 07/18/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____

AMBER KARY
DIRECTOR

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029221219

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	4	Date	07/18/22
No. of Repeat RF/PHI Categories Out	0	Time In	01:30:11
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Twin Cities Assisted Living	2814 Colfax Avenue North	Minneapolis, MN	55411	6124408001

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038633		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls: _____

Person in Charge (Signature) **Date:** 07/25/22

Inspector (Signature) Samuel McClintock