Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 2, 2023

Licensee
Three Links
809 Forest Avenue
Northfield, MN 55057

RE: Project Number(s) SL30702015

Dear Licensee:

On October 9, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 19, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 19, 2023 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 19, 2023, found not corrected at the time of the October 9, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1)

The details of the violations noted at the time of this follow-up survey completed on October 9, 2023 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

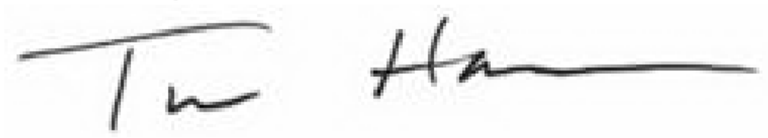
Please address your cover letter for reconsideration requests to:

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

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,



Tim Hanna, Interim Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30702	A. BUILDING: _____ B. WING _____	R 10/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS	809 FOREST AVENUE NORTHFIELD, MN 55057

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project # SL30702015-1 On October 9, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed between July 17, 2023, and July 19, 2023. At the time of the survey, there were thirty-three (33) active residents receiving services under the Assisted Living Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}		
{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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 1 This MN Requirement is not met as evidenced by: No further action needed.	{0 480}		
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be 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: No further action needed.	{0 510}		
{0 780} SS=E	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	{0 780}		

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{0 780}	Continued From page 2 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 interconnected smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On October 9, 2023, between 11:45 a.m. and 1:00 p.m., survey staff toured the facility with the environmental services director (ESD)-I. During the facility tour, survey staff observed in Cottage East that the battery-operated sleeping room smoke alarms had not been replaced since the	{0 780}		

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{0 780}	Continued From page 3 previous survey on July 17, 2023. The ESD-I explained that the facility plans to install smoke detectors with horn strobes but the smoke detectors were on backorder. The ESD-I explained that once the smoke detectors and horn strobes are installed, the system will be interconnected in the dwelling unit so that actuation of one alarm will cause all alarms to operate. This deficient condition was verified by the ESD-I accompanying on the facility tour.	{0 780}		
{0 900} SS=F	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	{0 900}		

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{0 900}	Continued From page 4 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 by: No further action needed.	{0 900}		
{01640} SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	{01640}		

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{01640}	Continued From page 5 by: No further action needed.	{01640}		
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action needed.	{01750}		
{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action needed.	{01890}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or	{01940}		

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{01940}	Continued From page 6 therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action needed.	{01940}		
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	{02170}		

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{02170}	Continued From page 7 (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: No further action needed.	{02170}		

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{02170}	Continued From page 8	{02170}		

Electronically Delivered

July 28, 2023

Licensee
Three Links
809 Forest Avenue
Northfield, MN 55057

RE: Project Number(s) SL30702015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30702015-0 On July 17, 2023, through July 19, 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 32 residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 17, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the	0 510		

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0 510	Continued From page 2 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 and interview, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control related to glove use for one of two unlicensed personnel ((ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-A was hired on October 12, 2016. On July 18, 2023, at 8:01 a.m., ULP-A provided medication administration, blood glucose checks, and activities of daily living to R2. ULP-A completed hand hygiene with the use of hand sanitizer and donned (put on) gloves. ULP-A gathered R2's supplies for blood glucose monitoring and medications to be administered to R2. ULP-A proceeded to R2's room from the medication room. ULP-A administered R2's oral	0 510		

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	30702	A. BUILDING: _____ B. WING _____	07/19/2023

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0 510	Continued From page 3 medications and checked R2's blood glucose with the use of a FreeStyle Libre system (a contactless device used to check blood glucose without the need of pricking the finger and obtaining a blood drop). ULP-A then cleaned the back of R2's right arm to administer R2's insulin and Victoza via subcutaneous injection. ULP-A doffed (removed) their gloves, gathered the supplies they brought to R2's room, returned to the medication cart, placed sharps in the sharp's container, place garbage in trash receptacle, returned supplies to the medication cart, documented using the keyboard and mouse for the computer, and then proceeded to wash their hands in the kitchen sick outside of the medication room. On July 19, 2023, at 10:00 a.m., clinical nurse supervisor (CNS)-D stated the licensee's expectation is for all employees to complete hand hygiene prior to donning and immediately upon doffing gloves. CNS-D stated ULP-A would have contaminated all surfaces touched after doffing gloves and not completing hand hygiene immediately after. The licensee's 8.07 Gloves policy dated May 22, 2022, indicated hand hygiene would be completed prior to donning gloves and after doffing and placing gloves in a proper receptacle. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 4 (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 interconnected smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 780		

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0 780	Continued From page 5 or has the potential to affect a large portion or all of the residents). Findings include: On July 17, 2023, between 1:45 p.m. and 4:15 p.m., survey staff toured the facility with the environmental services director (ESD)-I. During the facility tour, survey staff observed that in Cottage East the sleeping room smoke alarms did not test as interconnected with the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. This deficient condition was verified by the ESD-I accompanying on the facility tour. 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 by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous	0 800		

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0 800	Continued From page 6 state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On July 17, 2023, between 1:45 p.m. and 4:15 p.m., survey staff toured the facility with the environmental services director (ESD)-I. During the facility tour, survey staff observed the following: 1. Handles were removed from the egress windows in resident bedrooms in Cottages East and West, which prevented these windows from opening. Fire sprinkler systems were not installed in these cottages. The ESD-I explained during the tour that one handle was available in each cottage that could be used to open a window. All paths of egress must be maintained to allow occupants to exit the building in a safe and efficient manner in the event of an emergency. 2. Water-damaged ceiling tiles were observed in the basement of Cottage East. 3. Cabinet locks were installed but not being used for chemical storage in the kitchens of Cottage West and Forest. These deficient conditions were verified by the ESD-I accompanying on the facility tour.	0 800		

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0 800	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 8 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to meet the evacuation drill frequency requirement. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On July 17, 2023, at approximately 4:15 p.m., records were provided for review. Records were reviewed by survey staff on July 17, 2023, between 4:15 p.m. and 4:45 p.m. Record review of documented evacuation drills indicated that evacuation drills for employees had not been conducted during October and November of 2022. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On July 17, 2023, at approximately 5:00 p.m., the environmental services director (ESD)-I verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). On July 17, 2023, between 1:45 p.m. and 4:15 p.m., survey staff toured the facility with the environmental services director (ESD)-I. During the facility tour, survey staff observed the following:	0 820		

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0 820	Continued From page 10 1. In the East Cottage, a keypad lock that required a code to exit was provided on the wall for the front door and a deadbolt lock was installed on this door. Additionally, a push-to-exit button was installed for this door. When the deadbolt lock was engaged, the push-to-exit button was tested and the door did not unlock. 2. In the West Cottage, a keypad lock that required a code to exit was provided on the wall for the marked exit patio door and a deadbolt lock was installed on this door. The ESD-I explained that they did not think the deadbolt lock would default to an unlocked position under activation of the fire alarm system. 3. A marked exit in West Cottage led to an outdoor space enclosed by a fence. A key-only lock was installed on the exterior side of the fence gate. All paths of egress must provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency. These deficient conditions were verified by the ESD-I accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
0 900 SS=F	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;	0 900		

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0 900	Continued From page 11 (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 by: Based on observation and interview, the licensee failed to execute a written contract with the required content for individuals who resided in the basement apartments of the licensee's assisted living facility with dementia care. 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	0 900		

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0 900	Continued From page 12 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Minnesota Statute 144G.08 dated 2022, indicated an adult is defined as a natural person who has attained the age of 18 years. An assisted living contract is defined as the legal agreement between a resident and an assisted living facility for housing and, if applicable, assisted living services. An assisted living facility is defined as a facility that provides sleeping accommodations and assisted living services to one or more adults. A resident is defined as an adult living in an assisted living facility who has executed an assisted living contract. On July 17, 2023, at 11:00 a.m. during a tour of licensee's campus, licensed assisted living director (LALD)-C identified Cottage East was located on the south portion of the campus as a continuous building which included licensee's Three Links Apartments. Cottage East housed residents identified by LALD-C as individuals who required a secured unit due to their diagnosis and care needs. Three Links Apartments was identified by LALD-C as the licensee's subsidized apartments for independent individuals over the age of 62 and were on limited income. The lower level of Cottage East was identified by LALD-C as a closed adult day care center and was no longer operational. Currently the space was utilized as storage for the licensee and the office of the recreational department. To the left of the lower level was a door with an illuminated, "Exit," sign. The door was secured with a passcode and when opened, led to a hallway with rooms for the Three Links Apartments. These rooms were occupied by individuals who lived under the independent	0 900		

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0 900	Continued From page 13 subsidized apartment housing. The rooms shared the foundation for the Cottage East and identified as part of the Cottage East building. On July 19, 2023, at 9:40 a.m. LALD-C stated an assisted living contract was not executed for the individuals who resided in the apartments in the lower level of Cottage East. LALD-C stated the licensee identified them as residing in the subsidized apartments and not under the assisted living with dementia care license as the reason no assisted living contract or individualized abuse prevention plan was executed or implemented for the individuals who resided there. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640		

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01640	Continued From page 14 (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 licensee or resident or resident's representative to document agreement of services to be provided for three of three residents (R2, R3, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on April 15, 2013. R2's Service Plan with Signatures with effective date of December 2, 2022, was fully authenticated on January 10, 2023. R2's Service Plan with Signatures with effective date July 17, 2023, identified by licensed assisted living director (LALD)-C as R2's current service plan included seven (7) services with a start date	01640		

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01640	Continued From page 15 after December 2, 2022. R2's current service plan revisions lacked authentication by the licensee, resident, or resident's representative. R3 R3 was admitted on March 2, 2022. R3's Service Plan with Signatures with effective date of November 28, 2022, was fully authenticated on January 4, 2023. R3's Service Plan with Signatures with effective date July 17, 2023, identified by LALD-C as R3's current service plan included eleven (11) services with a start date after November 28, 2022. R3's current service plan revisions lacked authentication by the licensee, resident, or resident's representative. R4 R4 was admitted on October 4, 2022. R4's Service Plan with Signatures with effective date of December 5, 2022, was fully authenticated on December 7, 2022. R4's Service Plan with Signatures with effective date July 17, 2023, identified by LALD-C as R4's current service plan included six (6) services with a start date after December 5, 2023. R4's current service plan revisions lacked authentication by the licensee, resident, or resident's representative. On July 18, 2023, at 12:00 p.m., LALD-C stated all service plans should be authenticated with each revision. Clinical nurse supervisor (CNS)-D stated the nurses are responsible for updating and authenticating service plans and revisions. CNS-D stated service plans are updated with	01640		

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01640	Continued From page 16 changes based on assessment and the nurse failed to obtain authentication when changes to the service plan occurred. The licensee's 6.08 Service Plan policy dated April 20, 2022, indicated authentication by the licensee and the resident or resident's representative would be obtain on each service plan and revisions to document agreement of services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure nursing staff administered prescribed insulin per manufacturer's instruction for one of two residents (R3).	01750		

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	30702	A. BUILDING: _____ B. WING _____	07/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE LINKS	809 FOREST AVENUE NORTHFIELD, MN 55057

(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
01750	Continued From page 17 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: R3's diagnoses included type 2 diabetes. R3's Service Plan dated December 30, 2022, indicated medication administration was assigned to unlicensed personnel (ULP). R3's physician orders dated June 22, 2023, included: Basaglar Kwikpen 100 unit/milliliter - inject 10 units subcutaneously (under the skin) every morning. R3's medication administration record (MAR) dated July 2023, included the instruction to prime the Kwikpen to two units and waste prior to administration. On July 18, 2023, at 8:56 a.m. licensed practical nurse (LPN)-F was observed setting up R3's 8:00 a.m. medications for administration. ULP-F retrieved insulin Basaglar Kwikpen from the medication cart. LPN-F prepped the Kwikpen with a needle, prepped upper right arm with an alcohol pad, LPN-F dialed pen to ten units and injected Basaglar insulin ten units mid-right deltoid (muscle). When surveyor asked about priming the Kwikpen prior to dialing up the dosage, LPN-F stated she hasn't primed the	01750		

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01750	Continued From page 18 Kwikpen due to the single use needle not allowing her to do that. On July 18, 2023, at 8:58 a.m. clinical nurse supervisor (CNS)-B verified R3's Basaglar Kwikpen should have been primed to two units and wasted prior to administration. When the surveyor asked CNS-B about the proper administration of the insulin, CNS-B stated it should have been given subcutaneously, not intramuscularly. CNS-B stated she would complete follow-up training with staff on insulin administration and priming of the pens. The manufacturer's instructions for Basaglar Kwikpen - insulin glargine injection solution dated November 2022, Basaglar needs to be primed before each injection. To prime the pen, turn the dose knob to select 2 units. Basaglar is injected under the skin (subcutaneously) of the stomach area, buttocks upper legs or upper arms. The licensee's 7.36 Insulin policy dated May 10, 2022, indicated staff would follow any special instructions related to the administration of insulin. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the	01890		

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01890	Continued From page 19 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 not expired for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 17, 2023, at 2:35 p.m. the locked medication cart was reviewed with registered nurse (RN)-G. The following expired medication for R5 was observed and confirmed with RN-G: -acetaminophen 500 milligrams (mg) had an expiration date of March 26, 2023; and -Mucus relief ER (extended release) 600 mg had an expiration date of May 11, 2023. On July 17, 2023, at 2:43 p.m. RN-G and licensed practical nurse (LPN)-F confirmed all the findings listed above. On July 17, 2023, at 3:12 p.m., clinical nurse supervisor (CNS)-D stated a med cart audit check list started about three weeks ago and the medication carts are going to start getting checked monthly by the nurse. CNS-D stated expired medications should be taken out of the	01890		

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01890	Continued From page 20 medication cart and disposed of. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940		

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01940	Continued From page 21 changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at 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: R3's diagnoses included type 2 diabetes. On July 18, 2023, at 8:56 a.m., the surveyor observed licensed practical nurse (LPN)-F perform a blood sugar check on R3 in her room. R3's service plan dated December 30, 2022, indicated R3 received assistance with eating, mobility, incontinence care, bathing, grooming, medication management, transfers, toileting, laundry, and housekeeping. R3's Assessment as of Date dated May 26, 2023, noted R3 required assistance with blood sugar checks. R3's July 2023 Medication Administration Record (MAR) noted "Accu-Chek Aviva Plus Strip use to	01940		

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01940	Continued From page 22 test blood sugar daily" with a spot for staff to initials to indicate the service had been provided and results. R3's service plan lacked a written statement of the treatment services being provided to include daily blood sugar check. In addition, R3's records lacked a treatment management plan to include documentation of specific resident instructions relating to the treatments or therapy administration. On July 18, 2023, at 12:50 p.m. clinical nurse supervisor (CNS)-D verified the service plan did not include treatment of blood glucose and the MAR did not include a range for blood sugar check. The licensee's 7.05 Treatment & Therapy Management Plan policy dated April 21, 2022, indicated all required content to be included and developed for each resident's treatment and therapy management plans and the treatment and therapy services would be included on each resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety	02040		

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02040	Continued From page 23 risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On July 17, 2023, at approximately 4:15 p.m., records were provided for review. Records were reviewed by survey staff on July 17, 2023, between 4:15 p.m. and 4:45 p.m. Record review of the available documentation indicated that the licensee had included a Hazard and Vulnerability Assessment Tool as part of the emergency preparedness plan. An assessment of the physical environment that identified safety risks or hazards on and around the property with	02040		

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02040	Continued From page 24 mitigation factors had not been completed. On July 17, 2023, at approximately 5:00 p.m., the environmental services director (ESD)-I verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior;	02170		

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02170	Continued From page 25 (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete an evaluation for activities with all the required content and failed to develop a daily structured activities based on the resident's evaluation for three of three residents (R2, R3, 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 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 17, 2023, at 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-C provided licensee's survey binder and stated the binder would include the daily activities calendar for all residents. Additionally, clinical nurse supervisor (CNS)-D stated all resident's activities evaluations would be included each resident's 2021 Uniform Nursing Assessment Tool.	02170		

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02170	Continued From page 26 R2 R2 was admitted on April 15, 2013. R2's 2021 Uniform Assessment Tool dated April 19, 2023, lacked evaluation of the following required areas for activities: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. R3 R3 was admitted on March 2, 2022. R3's 2021 Uniform Assessment Tool dated May 26, 2023, lacked evaluation related to the following: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -adaptations necessary for the resident to participate; and -identification of activities for behavioral interventions. R4 R4 was admitted on October 4, 2022. R4's 2021 Uniform Assessment Tool dated June 12, 2023, lacked evaluation related to the following: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -adaptations necessary for the resident to participate; and -identification of activities for behavioral	02170		

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02170	Continued From page 27 interventions. The licensee's untitled July 2023 calendar identified by LALD-C as licensee's current activities calendar, failed to reflect resident's activity preferences and needs. The calendars for each unique location, identified as Reflections, Forest, Cottage East, and Cottage West, included, "independent activity," to start each day. Following the independent activity, the calendar included days where the residents' other activity was watching a television show at 10:00 a.m. and no other activity following. On July 18, 2023, at 8:40 a.m., in Cottage East, unlicensed personnel (ULP)-H stated they are the only person who would provide cares to the residents for the entire shift. ULP-H stated they do not provide any activities to the residents besides turning on the television when requested. ULP-H stated licensee had an activities person who was recently hired and was supposed to complete activities with residents, but with multiple locations to cover, sometimes they did not come to the location. On July 18, 2023, from 9:30 a.m. to 10:30 a.m., during continuous observations in the Reflections location, no activity was completed by the licensee as indicated on the activities calendar. The calendar read on July 18, 2023, "10:00am sensory activity." At 10:30 a.m., the surveyor asked the ULP if an activity was to occur and who was supposed to complete the activity. The ULP stated the calendar indicated an activity should be occurring, but the person who should provide it was identified as the activities person. ULP stated no activity was completed and they were unsure if any activity would be completed with the residents.	02170		

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02170	Continued From page 28 On July 18, 2023, at 12:00 p.m., LALD-C stated the licensee was aware the current activities evaluation for each resident lacked the required content and the activities calendar lacked daily structured activities based on residents' evaluations. LALD-C stated the licensee had recently hire an activities person, but they were still in training. LALD-C stated the licensee would be working with the activities person to develop the activities evaluation with all required content and the development of a daily calendar to include activities based on each of the residents' evaluations. The licensee's 1.34 Activity Programming policy dated March 20, 2023, lacked identification of the required content of the activity evaluation to be completed for each resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

Minnesota Department of Health
Division of Environmental Health
Food, Pools, and Lodging
12 Civic Center Plaza, Se 2105
Mankato, MN

Type: Full
Date: *07/17/23*
Time: 11:30:31
Report: 1028231095

Food and Beverage Establishment Inspection Report

Location:
Reflections
809 Forest Avenue
Northfield, MN55057
Rice County, 66

Establishment Info:
ID #: 0039369
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5076648810
ID #:

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

The following orders were issued during this inspection.

4-200 Equipment Design and Construction

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

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

The internal thermometer in the "nourishment refrigerator" in the serving space outside of the main kitchen must be replaced as it is no longer accurate.

Comply By: 07/17/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

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

A handwashing poster must be provided at the handwashing sink in the serving space outside of the main kitchen.

Comply By: 07/17/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400ppm at Degrees Fahrenheit
Location: 3-Compartment Sink
Violation Issued: No

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *07/17/23*
Time: 11:30:31
Report: 1028231095
Reflections

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: -7 Degrees Fahrenheit - Location: Traulsen Freezer - Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: Dairy-Free Custard
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: True Refrigerator - Ambient
Violation Issued: No

Process/Item: Hot Holding
Temperature: 140 Degrees Fahrenheit - Location: Meatballs
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Cottage East Refrigerator - Ambient
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: Cottage West Refrigerator - Yogurt
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

The following food preparation and food serving spaces were inspected at the Three Links Campus:
- Main kitchen at Reflections Care Suites
- Serving kitchen at Reflections Care Suites
- Serving kitchen at Cottage On Forest
- Serving kitchen at Cottage East
- Serving kitchen at Cottage West

Food is prepared in the main kitchen and served at the serving kitchens listed.

This Report, although titled "Reflections", serves to cover the Food/Beverage Inspections at all of the above locations.

Type: Full
Date: *07/17/23*
Time: 11:30:31
Report: 1028231095
Reflections

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 1028231095 of 07/17/23.

Certified Food Protection Manager: Carla Wolfe-Bartusek

Certification Number: FM80673 Expires: 10/06/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Carla Wolfe-Bartusek
Culinary Manager

Signed: _____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us