Electronically Delivered

November 1, 2022

Administrator
Minnehaha Senior Living
3733 23rd Avenue South
Minneapolis, MN 55407

RE: Project Number(s) SL30780015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 5, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500

The total amount you are assessed is $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 reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 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
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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: SL30780015 On October 3, 2022, through October 5, 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 69 residents receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (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, 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 the 24-hour staffing schedule was posted in a central location for residents, staff and visitors to review as required. In addition, the licensee failed to have a system in place to ensure call lights were responded to promptly. This had the potential to affect all residents and staff.	0 470		

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0 470	Continued From page 2 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: 24-HOUR STAFFING SCHEDULE On October 3, 2022, at 10:50 a.m., during a tour, the surveyor observed the licensee lacked the posting of a daily staffing schedule developed by the clinical nurse supervisor to: - direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On October 3, 2022, at approximately 12:00 p.m., licensed assisted living director (LALD)-D acknowledged no staffing schedule was posted in a central location. LALD-D stated all schedules are located online and posted in the nursing office and only the staffing plan was posted. CALL LIGHT RESPONSES On October 4, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-D provided the surveyor with a Device Activity Report dated between September 20, 2022, and October 1, 2022. The pendant alarm response time ranged between five seconds and 208	0 470		

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0 470	Continued From page 3 minutes and 47 seconds. On October 5, 2022, at approximately 8:40 a.m., during an interview with R5 in her room, R5 reported that on October 2, 2022, at approximately 2:10 a.m., R5 was in great pain and called for help by pushing her pendant. R5 decided to call the emergency services (911) after waiting for over two hours. The emergency team reported to R5, that they had not seen any employee since they arrived in licensee's facility. Two of the emergency staff went to find any employee who was available for the shift. R5 reported that it took the emergency staff almost 20 minutes before they could find the employee. R5's Device Activity Report dated October 3, 2022, at 2:17:25 a.m., indicated the pendant alarm was on for 129 minutes and 52 seconds before there was a response. On October 5, 2022, at approximately 2:30 p.m., LALD-D acknowledged the pendant response times were an issue of concern for licensee. LALD-D stated licensee's management had started a pendant response competition with rewards for employees who have the shortest response average time in their shift. LALD-D stated in addition, the licensee was considering giving education to residents on the use of pendant call light system for emergency situations and that R5's issue had been investigated and necessary actions taken. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		

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0 480	Continued From page 4	0 480		
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: (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 adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents of 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:	0 480		

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0 480	Continued From page 5 Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated October 3, 2022. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an effective infection control program to comply with acceptable health care, medical, and nursing standards for infection control. This deficient practice had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 510		

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0 510	Continued From page 6 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: BLOOD GLUCOSE On October 4, 2022, at approximately 7:40 a.m., unlicensed personnel (ULP)-K administered medications, completed skin preparation, checked blood glucose, and administered an insulin injection to R7. On October 4, 2022, at approximately 7:45 a.m., ULP-K recorded blood glucose level as 190 milligrams per deciliter (mg/dl), then took the blood glucose lancet and disposed it in a trash container. On October 4, 2022, at approximately 7:50 a.m., ULP-K stated all injection needles are put in the Sharps container but had always placed the lancets in the trash. On October 4, 2022, at approximately 10:35 a.m., registered nurse (RN)-A acknowledged the observations and stated all sharps, including lancets, are disposed of in a Sharps container provided to all residents who received blood glucose checks. HALLWAYS AND ROOMS On October 3, 2022, at approximately 10:50 a.m., the surveyor observed dirty dishes with some leftover food (beans, stew, and some greens) in a cart on the second floor by the elevator.	0 510		

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0 510	Continued From page 7 On October 4, 2022, at approximately 7:40 a.m., the surveyor observed dirty dishes by the sink in R9's room. On October 4, 2022, at approximately 8:28 a.m., the surveyor observed dirty dishes on a table on the fourth floor by the elevators. On October 4, 2022, at approximately 8:43 a.m., the surveyor observed dirty dishes on a cart on the second floor by the elevators. On October 4, 2022, at approximately 8:50 a.m., the surveyor observed an undated English muffin, peanut butter, and grape jelly on the counter in the memory care unit on second floor. On October 4, 2022, at approximately 8:55 a.m., ULP-L stated the undated English muffin, peanut butter, and grape jelly had been sitting on the counter since yesterday. On October 5, 2022, at approximately 11:45 a.m., licensed assisted living director (LALD)-D acknowledged the observations and stated residents are requested to put dishes in the hallways for easy pick up. LALD-D stated in addition, the licensee is working on a better approach to handle the situation but meanwhile they had bigger issues to address. The licensee's undated Infection Control policy indicated an essential element of the facility's infection control program is the development and revision of written policies and procedures to conform to current standards of practice and/or address specific concerns. The policy lacked the specifics of the issues addressed above. No further information was provided.	0 510		

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0 510	Continued From page 8 TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee tuberculosis (TB) baseline screenings were completed and documented for two of two employees (unlicensed personnel (ULP)-H, licensed practical nurse (LPN)-J). 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	0 660		

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0 660	Continued From page 9 number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee's Facility TB risk assessment dated May 22, 2022, indicated the licensee's facility was low risk. ULP-H began employment with the licensee on February 12, 2022. On October 5, 2022, at approximately 8:30 a.m., the surveyor observed ULP-H assisted completing activities of daily living for R5 in her room. ULP-H's employee record included a first step tuberculin skin test (TST) completed on January 31, 2022, but lacked the results of the test. ULP-H's employee record also lacked a second step TST. Licensed practical nurse (LPN)-J began employment with the licensee on August 1, 2022. LPN- J's employee record included a first step tuberculin skin test (TST) completed on July 27, 2022, but lacked the results of the test. LPN-J's employee record also lacked a second step TST. On October 5, 2022, at approximately 12:50 p.m., licensed assisted living director (LALD)-D acknowledged the two employee files lacked required first and second TSTs. LALD-D stated the licensee had realized some employees'	0 660		

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0 660	Continued From page 10 records were missing the same content, hence the licensee had started doing TB blood test for all its new employees. The licensee's TB Infection Control Plan dated September 2021, indicated the facility will have an infection control program in place to ensure that all residents, patients, and tenants are free form infectious tuberculosis. All health care settings are required by law to follow specific guidelines and measures to prevent and control TB. The policy also indicated employee screening will be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure maintenance of portable fire	0 790		

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0 790	Continued From page 11 extinguishers at the facility. 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 October 04, 2022, from approximately 9:30 a.m. to 11:00 a.m., survey staff toured the facility with the director of maintenance (DM)-F. During the facility tour, survey staff observed the inspection tags on the portable fire extinguishers were from July 2021. An annual inspection had not been completed. DM-F verbally confirmed survey staff observations during the facility tour. DM-F stated he had just joined the facility full-time and would get the inspection done as quickly as possible. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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	0 800		

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0 800	Continued From page 12 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 facility's 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 October 04, 2022, from approximately 9:30 a.m. to 11:00 a.m., survey staff toured the facility with the director of maintenance (DM)-F. During the facility tour, survey staff observed the following: 1. The carpet on the fourth floor was worn and had rips and fraying in transition areas. DM-F stated the flooring was on the maintenance schedule to be replaced over the next few months. 2. The communications room on the fourth floor by room 432 was being used as storage. There was no clear floor space in front of the electrical panels and the path to access the panels was	0 800		

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0 800	Continued From page 13 obstructed by miscellaneous items in storage. 3. The housekeeping closet on the third floor had items stored in the clear floor space of the electrical panels obstructing access. 4. The exhaust fan in the second-floor, memory care laundry room was covered in lint and dust. 5. The rated door from the dining room to the kitchen did not close and latch on its own. 6. Lower portion of the wall by the dining room bathroom entrance had an opening of approximately 2'-0" x 1'-0" exposing conduit. 7. Floor tiles by the dining room bathroom entrance were loose, cracked, and stained. 8. The sprinkler heads throughout the first floor were covered with dust and lint. 9. The trash chute fire cover in the basement trash room was not working. The door was not secured with a fusible link and would not shut by itself when tested. 10. Exhaust fans throughout the bathrooms in the facility were covered in dust and lint obstructing the proper function of the exhaust fan. 11. The gate on the outdoor patio was secured with a chain and padlock. This was the only exit from the patio space and was also part of an exit pathway for one of the stair towers. DM-F verbally confirmed survey staff observations during the facility tour. No further information was provided.	0 800		

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0 800	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (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 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all residents). The findings include: During interview on October 04, 2022, at 11:15 a.m., the executive director (LALD)-C and the director of operations (LALD)-D stated they had not done any training or drills by the date of the survey. Review of the fire policy showed the following: 1. No record of required employee evacuation drills. 2. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation.	0 810		

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0 810	Continued From page 16 3. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the unlicensed personnel (ULP) performing delegated	01330		

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01330	Continued From page 17 nursing task in the assisted living facility completed training and demonstrated competency in all required areas for two of two employees (ULP-B, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B ULP-B was hired on March 30, 2022. On October 4, 2022, at 8:00 a.m., the surveyor observed ULP-B assist R2 with medication administration. ULP-H ULP-H was hired on February 12, 2022. On October 5, 2022, at 8:00 a.m., the surveyor observed ULP-H assist R5 in her room with morning activities of daily living. ULP-B and ULP-H's Lifespark Orientation Packet dated March 30, 2022, and February 23,2022, respectively, lacked competency evaluations for the following required topics: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing (ii) care of teeth, gums, and oral prosthetic devices	01330		

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01330	Continued From page 18 (iii) care and use of hearing aids (iv) dressing and assisting with toileting - range of motioning and positioning. On October 5, 2022, at approximately 12:00 p.m., registered nurse (RN)-A acknowledged ULP-B and ULP-H's records lacked competency evaluations for the above topics. The licensee's Education policy dated April 2021, indicated all staff to be trained and competent with current practice standards appropriate to the client's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01330		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.	01620		

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01620	Continued From page 19 (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conduct ongoing client monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for three of five residents (R1, 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) 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 R1 started services with the licensee on February 18, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021, and had diagnoses to include spastic diplegic cerebral palsy (muscle stiffness in the legs), muscle weakness, hypertension, type 2 diabetes and suicidal ideations. R1's service plan dated August 26, 2022,	01620		

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01620	Continued From page 20	01620		

indicated R1 was receiving the following services: medication administration, blood glucose monitoring, and comprehensive nursing assessment.

R1's resident record included two ongoing resident monitoring assessments completed on June 17, 2022, and October 3, 2022. The assessments were 108 days apart, which was more than the required 90 days from the last date of the last assessment.

R3
R3 admitted for services on September 23, 2020. R3's diagnoses included, but were not limited to, hypertension and type 2 diabetes.

R3's service plan dated September 07, 2022, indicated R3 received services including medication administration and assistance with showering, laundry, meal, and activity reminders.

R3's record included a Comprehensive Assessment dated November 01, 2021 and a Nursing Assessment dated August 15, 2022, however the assessments were nine months apart, which was more than the required 90 days from the last date of the last assessment.

R4
R4 started services with the licensee July 30, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021, and had diagnoses to include muscle spasms, muscle weakness, and moderate intellectual disabilities.

R4's service plan dated September 7, 2022, indicated R4 was receiving the following services: medication administration, safety checks,

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01620	Continued From page 21 compression garment and comprehensive nursing assessment. R4's resident record included two Annual/Change of Condition Assessments completed October 28, 2021, and July 14, 2022, respectively. The assessments were eight months apart, which was more than the required 90 days from the last date of the last assessment. On October 4, 2022, at 2:15 p.m., registered nurse (RN)-A acknowledged R1, R3, and R4's comprehensive assessments were over the required 90 days from the last date of the last assessment. RN-A stated their previous assessment program was not able to alert when the assessments were due, but that has changed with their new assessment program. The licensee's Comprehensive Assessment Schedule policy dated July 2014, and revised August 2022, indicated "nurses shall conduct assessments, monitoring and reassessments consistent with Comprehensive Home Care requirements and the individualized needs of each home care client". The policy also indicated ongoing resident monitoring and reassessment shall be conducted at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650		

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01650	Continued From page 22 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of seven residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01650		

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01650	Continued From page 23 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On October 4, 2022, at 9:30 a.m., the surveyor observed R2 lying in bed. There was an oxygen concentrator on and operating in the room. Clear plastic tubing led from the concentrator to R2. The tubing went around R2's ears and connected to a nasal cannula inserted into the R2's nose. R2's physician order dated August 7, 2022, indicated Oxygen two liters via nasal cannula as needed to help breathing. R2's Service Plan Agreement dated August 26, 2021, lacked to include the treatment of oxygen. On October 4, 2022, at 11:00 a.m., registered nurse (RN)-A acknowledged resident service plans should include all services provided by the licensee, including the treatment of oxygen. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained, including the expiration date for time sensitive medications, for one of one resident (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On October 4, 2022, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications and insulin to R7. R7's unsigned and undated physician orders indicated to check blood glucose twice daily and give insulin glargine 100 unit/milliliter - inject 36 units under the skin twice a day. On October 4, 2022, at 8:20 a.m., the surveyor observed R7's room refrigerator and noted two opened and undated insulin glargine 100 unit/milliliter pens. On October 4, 2022, at 10:00 a.m., registered nurse (RN)-A acknowledged R7's insulin pens were not dated with open dates. RN-A stated ULPs are taught to date any opened insulin pens with open date by use of the stickers and dispose of after 28 days if still left.	01890		

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01890	Continued From page 25 The licensee's Medication-Insulin policy dated March 2021, indicated unopened insulin pen store in refrigerator and once opened expires within 28 days. The policy lacked information about storage of opened insulin. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	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	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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
01940	Continued From page 26 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: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all the required content for three of three residents (R1, R2, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 R1 started services with the licensee on February 18, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1had diagnoses to include spastic diplegic cerebral palsy (muscle stiffness in the legs), muscle weakness, hypertension, type 2 diabetes and suicidal ideations. R1's service plan dated August 26, 2022, indicated R1 was receiving the following services: medication administration, blood glucose monitoring, and comprehensive nursing	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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
01940	Continued From page 27 assessment. R2 R2 started services with the licensee on September 14, 2021, under the assisted living services on August 1, 2021. R2 had diagnoses to include hypertension and difficult breathing. R2's service plan dated August 26, 2022, indicated R2 was receiving the following services: medication administration. R5 R5 started services with the licensee on June 28, 2022. R5's service plan dated August 29, 2022, indicated R5 received the following services: compression garment and catheter change. R1, R2, and R5's treatment or therapy management plans lacked the following content to include: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - 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.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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
01940	Continued From page 28 On October 4, 2022, at 12:45 p.m., registered nurse (RN)-A acknowledged R1, R2, and R5 lacked individualized treatment or therapy management plans to include all the content above. The licensee's Medications and Treatments policy dated March 2021, indicated the licensee would "ensure medications and treatments systems are in accordance with the Comprehensive Home Care regulations". The policy lacked verbiage to include treatment or therapy management plan content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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
01960	Continued From page 29 were performed as ordered for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's physician order dated August 07, 2022, indicated supplemental oxygen at two liters was supposed to be administered via nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a person in need of respiratory,) as needed for comfort. On October 04, 2022, at 9:30 a.m., the surveyor observed R2 lying in bed. There was an oxygen concentrator on and operating in the room. Clear plastic tubing led from the concentrator to R2. The tubing went around R2's ears and connected to a nasal cannula inserted into the R2's nose. On October 04, 2022, at 9:30 a.m., unlicensed personal (ULP)-I confirmed oxygen was " used overnight, when in bed" for R2. R2's medication administration record (MAR) dated August 7 through October 04, 2022, did not indicate staff administered oxygen to R2. On October 04, 2022, at 11:35 a.m., registered nurse (RN)-A verified R2's MAR documentation had not occurred as required.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

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
01960	Continued From page 30 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02090 SS=F	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a dignified dining experience for all the licensee's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 3, 2022, between 11:55 a.m., and 12:50 p.m., during lunch period, the surveyor observed in the first-floor assisted living dining room all the residents were served food on Styrofoam plates.	02090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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
02090	Continued From page 31 On October 4, 2022, between 7:55 a.m., and 8:50 a.m., during breakfast period, the surveyor observed in the first-floor assisted living dining room and second-floor memory care unit dining room, all the residents were served food on Styrofoam plates. On October 4, 2022, at approximately 8:10 a.m., the surveyor observed R10 sat alone in the dining room during the breakfast meal period. R10 stated she had been waiting for over 15 minutes to be attended. R10 also stated no one had given her medications that morning either. At 8:25 a.m., resident service aide (RSA)-L took R10's order to serve her breakfast, and at 8:40 a.m., R10 received her breakfast. On October 4, 2022, at 9:50 a.m., RSA-L stated there was no one else to help, it was up to RSA-L to take the resident orders and serve them before starting to clean. In addition, RSA-L stated there was nothing he would do to improve the waiting time if he was working alone. On October 4, 2022, at 12:00 p.m., licensed assisted living director (LALD)-D acknowledged the observations and stated the licensee was in process of building a strong team by giving lead team monthly training. The licensee had also changed some roles to make the resident experiences more favorable. LALD-D added that everything was in the implementation stage and the residents would not notice any improvements yet. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02110	Continued From page 32	02110		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEHAHA SENIOR LIVING	3733 23RD AVENUE SOUTH MINNEAPOLIS, MN 55407

(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
02110	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care (ALFDC) were provided to residents and the residents' legal and/or designated representatives at the time of move in for two of four residents (R1, 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) 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 started services with the licensee on February 18, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3 started services with the licensee on September 23, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. The licensee failed to develop, implement, and provide dementia policies and procedures for R1 and R3 and all residents residing at licensee that addressed: - philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30780	A. BUILDING: _____ B. WING _____	10/05/2022

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
02110	Continued From page 34 nonpharmacological practices that are person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medication, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities are implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and drills only; - transportation coordination and assistance to and from outside medication appointments; and - safekeeping of resident's possessions. On October 4, 2022, at 11:20 a.m., registered nurse (RN)-A, and licensed assisted living director (LALD)-D acknowledged all the residents had not received the required 10 dementia policies. LALD-D stated the licensee had developed the policies and will provide them to the residents and residents' legal and/or designated representatives. No further information was provided TIME PERIOD FOR CORRECTION- Twenty-one (21) days	02110		

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

Type: Full
Date: *10/03/22*
Time: 12:00:00
Report: 1025221211

Food and Beverage Establishment Inspection Report

Location:
Minnehaha Senior Living
3733 23rd Avenue South
Minneapolis, MN55407
Hennepin County, 27

Establishment Info:
ID #: 0037976
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122380010
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.

3-500E Microbial Control: time as a control

3-501.19A ** Priority 2 **

MN Rule 4626.0408A Develop written procedures prior to using time as a public health control for time/temperature control for safety food and maintain the procedures in the food establishment.

Milk maintained in ice bath for service; provide a written TPHC procedure of maintain a working supply of TCS foods (e.g. milk) outside of mechanical refrigeration (6 hours for use or discard < 70 deg F, milk was at 41 deg F).

Comply By: 10/03/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

Provide a means of verifying the internal contact temperature of items sanitized in the hot water/high temp dish machine.

Comply By: 10/07/22

Surface and Equipment Sanitizers

Hot Water: = at 157 Degrees Fahrenheit
Location: Dish machine 165 W 182R 157C
Violation Issued: No

Hot Water: = at 162 Degrees Fahrenheit
Location: " 165W 192R 162C
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: 3 compartment sink dispenser
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Juice, non TCS
Temperature: 38 Degrees Fahrenheit - Location: Expo cooler, server area
Violation Issued: No

Process/Item: Egg salad
Temperature: 41 Degrees Fahrenheit - Location: Serving line
Violation Issued: No

Process/Item: Tomato, sliced
Temperature: 41 Degrees Fahrenheit - Location: Serving line
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: TPHC ice water
Violation Issued: No

Process/Item: Chicken, cooked
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Deli meat
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Ambient
Temperature: 38 Degrees Fahrenheit - Location: Upright cooler
Violation Issued: No

Process/Item: Ground beef, pkg
Temperature: 41 Degrees Fahrenheit - Location: Undercounter prep cooler
Violation Issued: No

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

Memory care serving kitchen reported closed due to water. To be rebuilt without appliances. If food will be dished or served from this area, provide approved finishes (e.g. smooth, durable, easily cleanable, and non absorbent) for the space. No commissary, grab and go, etc. reported.

Discussed employee health and hygiene, illness reporting and exclusion; date marking TCS foods prepared or opened in establishment (esp deli cheese, meat); resealing around the dish machine with mildew-resistant material, pest control and employee item storage, outbreak response, W/R/S of food contact surfaces every 4 hours (e.g. cutting/prep board); process for cooling TCS foods; 3 compartment sink usage (items washed but sanitized in dish machine except for long prep board; cleaning of non-food contact surfaces (ice machine, juice dispenser); mop hangers for utility sink; servicing of water filters; ensure staff are sanitizing the prep board in a "sanitized" sanitize compartment, in case people are washing in multiple compartments across shifts because items are usually dish machine sanitized)
Pastured eggs used, no raw animal foods served raw or undercooked (Highly Susceptible Population

requirements)
For non-potluck outdoor events/food where residents/customers are served, provide portable handwashing (e.g. SEFS)
Meals to quarantine rooms served on disposable product
Unable to determine rinse PSI on dish machine; has a digital display, check with servicer as to how to read the PSI, as it should be included as part of regular equipment testing (e.g. Wash Temperature, Rinse Temperature, Contact Temperature, and Rinse Pressure would all be appropriate columns for a daily checklist, it's what was tested during the inspection)
Provide a test kit the vegetable wash solution, when used

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 1025221211 of 10/03/22.

Certified Food Protection Manager: Scott; TBD

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Catie, Scott

Signed: _____
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025221211

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1	**Date** 10/03/22
No. of Repeat RF/PHI Categories Out	0	**Time In** 12:00:00
Legal Authority MN Rules Chapter 4626		**Time Out**

Minnehaha Senior Living	**Address** 3733 23rd Avenue South	**City/State** Minneapolis, MN	**Zip Code** 55407	**Telephone** 6122380010
License/Permit # 0037976	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

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
Surpervision			
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	X	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:** 10/05/22

Inspector (Signature) Cory Kline