Electronically Delivered

December 4, 2024

Licensee
Evergreen Assisted Living Homes Inc.
1215 Lake Lucy Road
Chanhassen, MN 55317

RE: Project Number(s) SL40093015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 17, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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

Per 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 residents/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.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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 MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm.

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40093	A. BUILDING: _____ B. WING _____	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN ASSISTED LIVING HOMES INC	1215 LAKE LUCY ROAD CHANHASSEN, MN 55317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40093015-0 On October 14, 2024, through October 17, 2024, 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 five (5) residents; all receiving services under the Provisional Assisted Living 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 14, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual	0 650		

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0 650	Continued From page 2 contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record included all the required content for one of two employees (unlicensed personnel (ULP)-B). 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).	0 650		

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0 650	Continued From page 3 The findings include: ULP-B was hired July 9, 2024, and provided direct cares for the residents of the facility. On October 15, 2024, from 8:30 a.m. to 9:00 a.m., ULP-B was observed administering medications to residents. ULP-B's employee record lacked a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision. During an interview on October 17, 2024, at 11:00 a.m., president (P)-D stated stated they completed job description for all staff, but they may have misplaced ULP-B's job description. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	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	0 660		

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0 660	Continued From page 4 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which includes documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-B). 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: The licensee's TB facility risk assessment dated December 10, 2023, indicated the facility was a low risk for TB. ULP-B was hired July 9, 2024, and provided direct cares for the residents of the facility. ULP's record included Baseline Tuberculin Skin Screening for health care worker (HCWs) dated	0 660		

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0 660	Continued From page 5 July 9, 2024, and a TST first step date administered April 10, 2024, and date read April 12, 2024. ULP-B's employee record lacked evidence of a second step TST or blood test. During an interview on October 17, 2024, at 11:00 a.m., president (P)-D stated ULP-B's employee record was missing a second step TST or blood test. P-D stated the licensee had policies and systems in place to ensure compliance with state regulations but was not sure why ULP-B's TB skin or blood testing was not completed. The licensee's Tuberculosis Infection Control Policy last revised April 2024 indicated "Prior to employment or assignment, all HCWs must undergo an initial tuberculosis screening utilizing a two-step Tuberculosis Skin Test (TST) or a single blood assay for Mycobacterium tuberculosis (BAMT)/interferon-gamma release assays (IGRAs)." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record.	0 660		

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0 660	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency disaster plan with all required content,	0 680		

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0 680	Continued From page 7 and the licensee failed to post the emergency disaster plan in a prominent location. This had the potential to affect all nine residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 14, 2024, at 11:30 a.m., during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted in a prominent location. The licensee's emergency disaster preparedness plan dated June 12, 2023, lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee;; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility) - shelter in place; - a tracking system used to document locations or residents and staff	0 680		

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0 680	Continued From page 8 - the medical record documentation system to preserve resident information - emergency staff strategies emergency management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families. On October 14, 2024, at 11:00 a.m., president (P)-D stated they were familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). P-D also verified the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. The licensee's Emergency Action Plan (EAP) policy revised April 2024, indicated the licensee would have in place a general emergency preparedness plan. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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:	0 780		

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0 780	Continued From page 9 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with statute requirements. This had the potential to directly affect a limited number of 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 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).	0 780		

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0 780	Continued From page 10 The findings include: On October 15, 2024, at 10:30 a.m., survey staff toured the home with president (P)-D. During the tour, the surveyor observed when the smoke alarms were tested, all of the required smoke alarms did not actuate. The dwelling unit smoke alarms were not interconnected as required by statute. During the facility tour interview, P-D verified the above listed observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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 install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors.	0 790		

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0 790	Continued From page 11 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 15, 2024, at 10:30 a.m., survey staff toured the home with president (P)-D. During the tour, the surveyor observed the following: 1. Monthly inspections were not recorded on the back of the tags attached to the portable fire extinguishers installed in the upper level hallway, garage, and kitchen. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. 2. The portable fire extinguisher in the kitchen was stored on the countertop and did not have a tag or label attached showing the annual maintenance inspection had been performed by certified service personnel. Fire extinguishers must be properly installed to prevent them from being moved or damaged. Annual maintenance inspections are required to ensure fire extinguishers are in good working order and ready to use in an emergency. During the facility tour interview on October 15, 2024, P-D verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN ASSISTED LIVING HOMES INC	1215 LAKE LUCY ROAD CHANHASSEN, MN 55317

(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
0 800 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 provide the physical environment in a continuous state of good repair and operation with regard to 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 of the residents). The findings include: On October 15, 2024, at 10:30 a.m., survey staff toured the home with president (P)-D. During the tour, the surveyor observed the following: 1. In occupied resident sleeping room 3, when the double hung egress window was lifted up, it would not stay open. Egress windows that do not operate properly could delay exiting in the event of a fire.	0 800		

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	40093	A. BUILDING: _____ B. WING _____	10/17/2024

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EVERGREEN ASSISTED LIVING HOMES INC	1215 LAKE LUCY ROAD CHANHASSEN, MN 55317

(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
0 800	Continued From page 13 2. A wire fence enclosed the space outside the egress window for resident sleeping room 5. Unobstructed paths for egress escape must be maintained to ensure the building occupants can quickly and safely evacuate in the event of an emergency. 3. An exit sign was posted over the door leading into the attached garage from the home. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. 4. Electrial devices were used improperly in these locations: - The chest freezer was plugged into an extension cord in the garage. - An extension cord was used to supply power in resident room 3. - The window air conditioner was plugged into a power strip in resident room 1. - A power strip was plugged into a multiplug adapter in resident room 1. - Extension cords were used for equipment in the lower level employee office and laundry room. - A refrigerator was plugged into a power strip. Improper use of extension cords and power strips creates a fire hazard. 5. Cardboard was stored next to the water heater in the mechanical room. Wood boards were stored on wall brackets adjacent to the fuel-fired heater installed on the ceiling in the garage. Clearances to combustible materials must be maintained per the manufacturer's instructions. 6. Both of the casement windows in the basement family room were labeled as exits on the posted floor plan. The handle used to open the window was missing from window #1. The blind for window #2 was broken and did not operate properly. Designated exits must be properly maintained to allow the occupants to safely exit the building in the event of an emergency.	0 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 14 7. There was an unlisted space heater stored in the lower level employee office.When space heaters are provided, the space heater must be certified by a recognized testing laboratory to ensure that it meets all required safety standards. During the facility tour interview on October 15, 2024, P-D verified the above listed observations. TIME PERIOD FOR CORRECTION: Two (2) 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	0 810		

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0 810	Continued From page 15 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content, and provide required training and drills. 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 potential to affect a large portion or all of the residents). The findings include: On October 15, 2024, at 10:30 a.m., survey staff toured the home with president (P)-D. During the tour, the surveyor observed room numbers were posted on all of the resident sleeping room doors. The posted floor plan labeled resident sleeping room 4 as a laundry room. The licensee failed to accurately identify the location of resident sleeping room 4 on the FSEP floor plan. Sleeping room numbers are required to be included on the	0 810		

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0 810	Continued From page 16 fire safety and evacuation floor plan and used with the numbers installed on the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. During the facility tour interview on October 15, 2024, P-D verified the posted floor plan was not accurate. On October 15, 2024, the P-D and house manager (HM)-E provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee failed to develop and maintain the FSEP evident by the following: A floor plan for the lower level, where the employee office was located, was not included in the FSEP. The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The licensee failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of all residents in the FSEP. The current resident census at the facility was five. The FSEP included the level of care emergency evacuation procedures for four residents. Record review of the available documentation indicated the evacuation drill policy had not been developed for the facility location. This policy	0 810		

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0 810	Continued From page 17 inaccurately referenced evacuation through neighboring smoke compartment doors. During an interview on October 15, 2024, at 1:00 p.m., P-D verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation to support this had been completed. Two employee training attendance records were provided. One dated September 6, 2024, listed fire drills as the topic. A second training attendance record dated September 2024 listed workplace safety as the topic. These records did not list FSEP as a topic for these trainings. Records documenting employee training on the FSEP were requested by the surveyor but not provided. Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of training records to support this has been completed. Records documenting resident training on fire safety and evacuation were requested by the surveyor but not provided. During an interview on October 15, 2024, at 1:00 p.m., P-D verified additional training records for employees and residents were not available. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by fire drill reports lacking the required frequency. Six employee fire drills were recorded in 2024, three were	0 810		

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0 810	Continued From page 18 completed in July and three in September. No evacuation drill records for 2023 were provided. During an interview on October 15, 2024, at 1:00 p.m., P-D verified no additional drill records for the facility were available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for two of one resident (R1). This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 970		

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0 970	Continued From page 19 The findings include: On October 17, 2024, at 11:00 a.m., president (P)-D provided an undated occupant agreement and indicated the contract was used by the licensee for all residents who received services. R1's record included an occupant agreement signed January 1, 2024. R1's contract indicated "The facility is not responsible for loss of any property belonging to you due to theft or any other cause. You are responsible for purchasing and maintaining insurance to cover damage to or the loss of your property." During an interview on October 17, 2024, at 11:00 a.m., president (P)-D acknowledged R1 and the licensee's assisted living contract included a waiver of liability for health and safety or personal property. P-D stated the contract would be revised. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

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01620	Continued From page 20 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on January 10, 2024. R1's 90-day assessment Nurse Note dated	01620		

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01620	Continued From page 21 October 14, 2024, indicated "The visit today was done remotely; the patient care plan was updated. Patient Parkinson's has progressed and is showing more decline." R1's record included an Admission Assessment dated May 20, 2024; a Clinical Update Assessment dated June 17, 2024; and a Clinical Update Assessment dated October 14, 2024 (after initiation of the survey) and indicated: needs help with transfer - one person assist. On October 15, 2024, at 11:00 a.m., the surveyor observed unlicensed personal (ULP)-B and ULP-G assist R1 with a transfer using a gait belt. R1 was able to pivot with ULP-B and ULP-G's assistance and transferred to wheelchair. ULP-B and ULP-G changed R1's incontinence pad and provided perineal care in the bathroom. ULP-B reported R1 required assistance of two staff with transfers and mobility. ULP-B reported the nurses were working on getting a stand-up lift for R1. During interview on October 15, 2024, at 1:00 p.m., registered nurse (RN)-A acknowledged the last three nursing assessments, including the Clinical Update Assessment dated October 14, 2024, indicated R1 needed assistance of one staff person for transfers. RN-A stated R1 required two staff assistance with transfers, and this was not updated with the current assessment. President (P)-D sated it was the licensee's process to do change of condition assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01650	Continued From page 22	01650		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee to document agreement on the services to be provided for two of two residents	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01650	Continued From page 23 (R1, 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) 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: R1 R1 was admitted to the facility on January 10, 2024. R1's Admission Assessment dated May 20, 2024; Clinical Update Assessment dated June 17, 2024; and Clinical Update Assessment dated October 14, 2024 (after initiation of the survey) and indicated: needs help with transfer - one person assistance. R1's Service Plan -Modification dated January 1, 2024, indicated R1 received services to include medication administration, bathing assistance, transferring, dressing, and toileting/incontinence management. R1's record lacked a service plan with signature. R2 R2 was admitted to the facility on February 5, 2024. R2's Service Plan with effective date October 16, 2024 (after initiation of the survey), indicated R2 received services to include medication administration, bathing assistance, and manage	01650		

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01650	Continued From page 24 behavior. R2's record lacked a service plan with signature. During an interview on October 17, 2024, at 11:00 a.m., president (P)-D stated R1 and R2's service plans were missing signatures. P-D stated they were aware the service plan required a signature. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01650		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Follow-Up
Date: *10/17/24*
Time: 11:55:24
Report: 7963241119

Food and Beverage Establishment Inspection Report

Location:
EVERGREEN ASSISTED LIVING CARE
1215 LAKE LUCY ROAD
Chanhassen, MN55317
Carver County, 10

Establishment Info:
ID #: 0043730
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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 previously issued on 10/14/24 have NOT been corrected.

2-100 Supervision

2-102.12AMN

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

UNABLE TO VERIFY A CERTIFIED FOOD MANAGER. TWO EMPLOYEES HAVE STATED THAT AN APPLICATION AND FEE HAS BEEN MAILED INTO MDH. NO APPLICATION OR CHECK HAS BEEN RECEIVED. FACT SHEET AND APPLICATION SENT WITH REPORT.

Issued on: 10/14/24 *Comply By: 10/14/24*

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: AMBIENT TEMP
Temperature: 36 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-SANITIZING DISHES AND UTENSILS

-HIGHLY SUSCEPTIBLE POPULATION RESTRICTIONS
-CFM REQUIREMENTS
-COLD HOLDING AND SAME DAY SERVICE

THIS IS A RESIDENTIAL HOME USING SAME DAY FOOD SERVICE.
KITCHEN HAS SOLID SURFACE COUNTERTOPS, WOOD PAINTED CABINETS, WOOD FLOORING AND SMOOTH PAINTED CEILING.

USING A RESIDENTIAL DISHWASHER FOR CLEANING AND SANITIZING DISHES.

NEW REFRIGERATOR AND DISHWASHER INSTALLED OCT 2024

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 7963241119 of 10/17/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Eunie Buford

Signed:_____
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *10/14/24*
Time: 12:50:37
Report: 7963241117

Food and Beverage Establishment Inspection Report

Location:
EVERGREEN ASSISTED LIVING CARE
1215 LAKE LUCY ROAD
Chanhassen, MN55317
Carver County, 10

Establishment Info:
ID #: 0043730
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

REFRIGERATOR IS NOT HOLDING FOOD AT 41 DEG F OR COLDER.
MILK AT 46 DEG F, CREAM CHEESE AT 44 DEG AND LUNCH MEAT AT 42 DEG F.
INSTRUCTED THEM TO ADJUST THE REFRIGERATOR TO A COOLER TEMPERATURE.

Comply By: 10/14/24

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

UNABLE TO VERIFY THAT THE DISHWASHER REACHES AT A LEAST A SURFACE TEMPERATURE OF 160 DEG F. INSTRUCTED TO USE THREE BUCKET METHOD AND USE A SANITIZER SOLUTION UNTIL DISHWASHER IS REPAIRED/REPLACED.

Comply By: 10/14/24

2-100 Supervision

2-102.12AMN

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

UNABLE TO VERIFY A CERTIFIED FOOD MANAGER. TWO EMPLOYEES HAVE STATED THAT AN APPLICATION AND FEE HAS BEEN MAILED INTO MDH.

Type: Full
Date: *10/14/24*
Time: 12:50:37
Report: 7963241117

Food and Beverage Establishment Inspection Report

EVERGREEN ASSISTED LIVING CARE

Comply By: 10/14/24

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 46 Degrees Fahrenheit - Location: KITCHEN FRIG
Violation Issued: Yes

Process/Item: CR CHEESE
Temperature: 44 Degrees Fahrenheit - Location: KITCHEN FRIG
Violation Issued: Yes

Process/Item: LUNCH MEAT
Temperature: 42 Degrees Fahrenheit - Location: KITCHEN FRIG
Violation Issued: Yes

Process/Item: MILK
Temperature: 34 Degrees Fahrenheit - Location: BASEMENT FRIG
Violation Issued: No

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

MET WITH EUNIE BUFORD. DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-SANITIZING DISHES AND UTENSILS
-HIGHLY SUSCEPTIBLE POPULATION RESTRICTIONS
-CFM REQUIREMENTS
-COLD HOLDING AND SAME DAY SERVICE

THIS IS A RESIDENTIAL HOME USING SAME DAY FOOD SERVICE.

KITCHEN HAS SOLID SURFACE COUNTERTOPS, WOOD PAINTED CABINETS, WOOD FLOORING AND SMOOTH PAINTED CEILING.

USING A RESIDENTIAL DISHWASHER FOR CLEANING AND SANITIZING DISHES.

Type: Full
Date: *10/14/24*
Time: 12:50:37
Report: 7963241117
EVERGREEN ASSISTED LIVING CARE

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 7963241117 of 10/14/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Eunie Buford

Signed:_____
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963241117

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

No. of RF/PHI Categories Out	3	Date	10/14/24
No. of Repeat RF/PHI Categories Out	0	Time In	12:50:37
Legal Authority MN Rules Chapter 4626		Time Out	

EVERGREEN ASSISTED LIVING	**Address** 1215 LAKE LUCY ROAD	**City/State** Chanhassen, MN	**Zip Code** 55317	**Telephone**
License/Permit # 0043730	**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
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygenic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 10/15/24

Inspector (Signature) Peggy Spudy