DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 14, 2023

Licensee
New Perspective - Woodbury
2195 Century Avenue South
Woodbury, MN 55125

RE: Initial License Number 408125
Health Facility Identification Number (HFID) 31733
Project Number(s) SL31733015
Complaint Evaluation Number(s) HL31733001M/002C and HL31733003M/004C

Dear Licensee:

On February 1, 2023, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed September 15, 2022. The follow-up evaluation found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 24, 2023.

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 Rhylee Gilb, at 651-201-5977.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered
October 26, 2022

Administrator
New Perspective - Woodbury
2195 Century Avenue South
Woodbury, MN 55125

RE: Conditional License Number 408125
Health Facility Identification Number (HFID) 31733
Licensing Evaluation Number(s) SL31733015
Complaint Evaluation Number(s) HL31733001M/002C and HL31733003M/004C

Dear Administrator:

The Minnesota Department of Health (MDH) completed a licensing evaluation on September 15, 2022, for the purpose of assessing compliance with state licensing statutes. In addition, complaint evaluation(s) HL31733001M/002C and HL31733003M/004C were completed on May 5, 2022, and are being considered in our determination under this enforcement action. Based on both evaluation results, you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

Based on the licensing and complaint evaluations, which resulted in five (5) level 3 tags being cited and an instance of substantiated maltreatment was found, including one tag (2560) cited at level 3 specific to the retaliation prohibition.

As a result, MDH is issuing a 90-day conditional license due to expire on January 24, 2023.

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 - $500.00

The total amount you are assessed is $500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Conditional License Issued:
MDH will issue New Perspective - Woodbury a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluations, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluations, MDH will determine if New Perspective - Woodbury is in compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** New Perspective - Woodbury will not admit any new residents under its conditional assisted living facility license until the MDH removes the “no new admissions” condition. New Perspective - Woodbury

must provide the Department:

i. A list of the names and birthdates of any individuals New Perspective - Woodbury is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents by location including:
    1. Name and birthdate of each resident
    2. Physical location of each resident
    3. Current payment source for services
    4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: New Perspective - Woodbury will contract with an RN to provide consultation concerning all resident(s) to whom New Perspective - Woodbury provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from New Perspective - Woodbury. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with New Perspective - Woodbury and MDH must review the RN's credentials and approve the selection. New Perspective - Woodbury is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to New Perspective - Woodbury in an effort to help New Perspective - Woodbury align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward compliance and/or concerns about observations. New Perspective - Woodbury will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies New Perspective - Woodbury and the RN consultant about a change. Each report will be electronically submitted to Rhylee Gilb, Evaluator Supervisor, State Rapid Response Team, Health Regulation Division, at rhylee.gilb@state.mn.us. Rhylee Gilb can be reached at 218-232-8285 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of New Perspective - Woodbury to correct the violations cited during the evaluations as well as to determine the overall practice of New Perspective - Woodbury in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluations, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: New Perspective - Woodbury will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing compliance for each corrected order

Results of Follow-Up Survey During the Conditional License Period:
MDH will determine if New Perspective - Woodbury is in compliance based on the results of the follow up evaluations. MDH will make this determination within the 90-day conditional license period. If MDH determines New Perspective - Woodbury is in substantial compliance on the follow up evaluations, MDH will remove the conditions from New Perspective - Woodbury's assisted living facility license, and New Perspective - Woodbury will correct violations identified during the evaluations to come into full compliance. If MDH determines New Perspective - Woodbury is not in substantial compliance, MDH may take additional enforcement action against New Perspective - Woodbury, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

Request a Hearing:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing 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
Health.HRD.Appeals@state.mn.us

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

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

Request 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 notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Rhylee Gilb directly at: 218-232-8285.

Sincerely,

Maria King

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31733	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WOODBURY	2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: Project #SL31733015 On September 12, through September 15, 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 70 residents; 65 receiving services under the provider's Assisted Living with Dementia Care license.	0 000	*****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.01 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project #SL31733015 On September 12 through September 15, 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 seventy (70) residents receiving services under the provider's Assisted Living with Dementia Care Facility license.	
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	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31733	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 480	Continued From page 1 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 ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 70 residents of the assisted living with dementia care 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 13, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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0 480	Continued From page 2 (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 accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. The licensee failed to ensure appropriate personal protective equipment was worn for one of two employees (unlicensed personnel (ULP)-C), when observed to deliver cares to residents. This had the potential to 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, 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	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 510	Continued From page 3 has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 13, 2022, at approximately 7:30 a.m., during morning medication administration to multiple residents, ULP-C failed to complete appropriate hand hygiene prior to providing medication management and donning (put on) and doffing (take off) gloves. Additionally, ULP-C failed to wear protective goggles while providing services to each resident. ULP-C donned gloves without completing hang hygiene and prepared each resident's medication at the medication cart in the common hallway. ULP-C entered each resident's room and administered their respective medications without placing the appropriate eye protection prior to entering the rooms. ULP-C returned to the medication cart after administration of the medications and doffed the gloves without completing hand hygiene. On September 13, 2022, at approximately 7:30 a.m., ULP-C stated they were trained by the licensee at their corporate offices for the proper medication administration procedure and service delivery to residents. On September 13, 2022, at approximately 9:00 a.m., while surveyor completed general observations of the memory care unit, a ULP was noted to be exiting a resident's room with their mask below their chin, full face exposed, and no eye protection noted to be in place. The ULP stated they had just finished helping a resident with activities of daily living. Additionally, a kitchen staff member was observed exiting the kitchen	0 510		

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0 510	Continued From page 4	0 510		

with their face mask worn below their nose as they brought a tray of food into the common dining area with residents seated at multiple tables for breakfast. Both staff corrected the placement of their face masks when each noted the surveyor's presences.

The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with residents without suspected or confirmed SARS-CoV-2 infection.

The CDC COVID Data Tracker on September 13, 2022, indicated Washington County, Minnesota (the county of the assisted living facility) was at a "high" level of community transmission, which indicated the use of a face mask and eye protection while working with residents.

On September 13, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-E and director of nursing (DON)-F acknowledged the employees were not following the licensee's infection control expectations and policies.

The licensee's Infection Control Program policy dated July 6, 2022, indicated the licensee would follow the CDC recommendations for hand hygiene and proper hand hygiene would occur per the licensee's policies.

The licensee's Hand Washing policy dated November 5, 2021, indicated hand hygiene would

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0 510	Continued From page 5 be completed before and after direct contact with residents, and after removing gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=E	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for one of five residents (R2). The facility was aware of the incident but did not report the incident to the Minnesota Adult Abuse Reporting Center (MAARC). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 620		

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0 620	Continued From page 6 situation has occurred repeatedly; but is not found to be pervasive). The findings include: R6 was admitted on March 25, 2021, with diagnoses which included disorientation, major depressive disorder, history of falling, and anemia. R6's Resident Service Agreement dated February 25, 2022, indicated R6 resided in the licensee's locked memory care unit and received Service Type: Safety: Elopement Risk as the licensee was to, "Ensure [R6] is redirected and remains in safe and secure setting at all times unless escorted by a team member or family member." R6's Progress Notes dated March 20, 2022, at 12:12 p.m., signed by the facility registered nurse (RN), indicated R6 was located in the main entrance of the facility outside of the locked memory care unit at 7:30 a.m. without an escort or family member. R6 was escorted back to the secured memory care unit and the progress note read, "All the exits were promptly checked and confirmed in working order. Prior to finding [R6] outside the main doors, staff had helped [R6] sit down with a cup of coffee in the dining room. Management to follow-up today by checking security footage." No progress note indicated management completed follow-up or reviewed the events surrounding R6's elopement from the secured memory care unit. On September 13, 2022, at approximately 2:00 p.m., a request for the incident report or MAARC report related to R6's elopement was made by the survey team. Director of Nursing (DON)-F stated an incident report or MAARC report was not	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 620	Continued From page 7 created as the licensee believed R6 did not fully leave the facility and the situation was not considered an elopement. DON-F acknowledged R6 was required to reside in the licensee's locked memory care unit for R6's safety due to their cognition deficits. The licensee's Missing Resident and Elopement policy dated November 5, 2021, indicated the licensee would complete an incident report for all elopements and "file a report to the appropriate state agency if it is determined that a resident eloped, defined as a secured dementia unit resident leaving the secured dementia unit." The licensee's Accidents, Incidents, and Unusual Occurrences policy dated November 5, 2021, read when an incident report is filed, the licensee would, "When required by law, report to the state by filing a Minnesota Adult Abuse Reporting Center VA-CEP Report." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WOODBURY	2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 8 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency disaster preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all seventy (70) residents receiving services under the assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31733	A. BUILDING: _____ B. WING _____	09/15/2022

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0 680	Continued From page 9 On September 12, 2022, at approximately 11:00 a.m., during a facility tour, the surveyor observed the emergency preparedness plan (EPP) was not displayed prominently. The EPP was placed behind the reception desk out of view of the general public. The emergency disaster plan lacked the following required content: - names/contact information of residents' providers, pharmacy, or entities who provided services to residents. On September 14, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-E and director of nursing (DON)-F acknowledged it was not prominently displayed and lacked the above content. The licensee's Emergency Preparedness policy dated March 11, 2022, indicated the disaster evacuation plan would be prominently displayed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used	0 780		

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0 780	Continued From page 10 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 interconnection of smoke alarms in apartment units 136 and 203. This has the potential to directly affect 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 September 14, 2022, approximately from 10:30 a.m. to 1:55 p.m., survey staff toured the facility with the licensed assisted living director	0 780		

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0 780	Continued From page 11 (LALD)-E and the environmental services director (ESD)-G. During the tour, survey staff observed the ESD-G tested the smoke alarms inside the one-bedroom resident apartment unit 136 and the two-bedroom apartment unit 203, and the smoke alarms in each unit were not interconnected as required. This finding was evident as the smoke alarms in the units sounded local. Survey staff explained to the ESG-G and the LALD-E that the smoke alarms inside each bedroom and outside the vicinity of the bedrooms of each apartment unit must be interconnected such that when one alarm is activated, all smoke alarms inside the apartment must sound throughout the apartment unit. The ESG-G and the LALD-E verified the findings. On September 14, 2022, at approximately 2:45 p.m., during the exit interview, the LALD-E and the ESD-G acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 12 Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive 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 September 14, 2022, approximately from 10:30 a.m. to 1:55 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-E and the environmental services director (ESD)-G. During the tour, the following findings were observed: -The one-hour rated fire door to resident storage in the garage level failed to latch when closed. The door hardware needs to be repaired or replaced. -Resident apartment unit 156 had broken closet folding doors that were set against the side of the closet. -Resident apartment units 205 and 230 had stained carpet and needed to be cleaned. -Resident apartment units 136, 147, 161, and 255 had fuel-burning appliances inside each apartment unit but failed to have carbon monoxide alarms for compliance with state law. -The exhaust fan in the second floor laundry room was heavily layered with lint/dust. On September 14, 2022, at approximately 2:45	0 800		

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0 800	Continued From page 13 p.m., during the exit interview, the LALD-E and the ESD-G acknowledged the above findings. No further information was provided. 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	0 810		

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0 810	Continued From page 14 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 provide the complete content on the fire safety and evacuation plan, the minimum frequency of employee fire safety and evacuation drills, and the minimum required staff training on fire safety and evacuation. This has the potential to directly affect the safety of visitors, staff, and all residents receiving care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 September 14, 2022, at approximately 2:00 pm, survey staff received the facility fire safety and evacuation plan and related documentation for review from the licensed assisted living director (LALD)-E. Document review and interview with the LALD-E and the ESD-G at approximately 2:30 p.m. indicated the following findings: FIRE SAFETY AND EVACUATION PLAN 1) The fire safety and evacuation plan lacked complete fire protection procedures necessary to address employee actions to be taken in the	0 810		

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0 810	Continued From page 15 event of a fire or similar emergency and to address unique resident-specific situations during an evacuation from fire or similar emergency. Unique situations that must be considered during an evacuation could be residents who have mobility limitations, cognitive impairment, deaf or blind, or any residents needing assistance for movement during an evacuation that must be addressed in the fire safety and evacuation plan. 2) The plan lacked fire protection procedures necessary for residents TRAINING The licensee lacked a record of employee training specifically on the fire safety and evacuation plan. Survey staff explained that the employee training on the fire safety and evacuation plan in accordance with Minnesota Statutes is upon hire and at least twice a year thereafter, in addition to the annual required emergency preparedness plan training which was noted on the facility emergency preparedness document (page 28). FIRE and EVACUATION DRILLS The licensee failed to meet the minimum numbers of fire safety and evacuation drills that must be performed by employees twice per year per shift, with at least one evacuation drill every other month. No drill records were available for review. On September 14, 2022, at approximately 2:45 p.m., during the exit interview, the LALD-E and the ESD-G acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		

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0 970 SS=C	144.50 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 residency agreement did not include language waiving the licensee's liability for health, safety, or personal property of a resident. 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). The findings include: On September 12, 2022, licensed assisted living director (LALD)-E provided a blank Residency Agreement and indicated the contract was used by the licensee for all residents who received services. On page twenty-one (21) of the residency agreement, it indicated the licensee shall not be	0 970		

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0 970	Continued From page 17 liable for health and safety or personal property. On September 14, 2022, at approximately 10:30 a.m., LALD-E acknowledged the licensee's residency agreement included a waiver of liability for health and safety or personal property. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	01950		

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01950	Continued From page 18 Based on observation, interview and record review, the licensee failed to ensure specific written instructions were documented in one of one resident's (R5) record who received oxygen therapy. 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: R5's diagnoses included, but were not limited to, shortness of breath, vascular dementia without behavioral disturbance, transient cerebral ischemic attack (stroke), generalized anxiety disorder, and hypertension (high blood pressure). On September 13, 2022, at approximately 9:00 a.m., the surveyor observed an oxygen concentrator machine (concentrates and purifies the surrounding air to provide oxygen) next to the recliner and two oxygen cylinder tanks standing upright next to the wall within R5's room. R5's service plan dated September 13, 2022, indicated R5 would receive oxygen as needed for shortness of breath or difficulty breathing. R5's prescriber signed orders dated August 3, 2022, indicated oxygen-two (2) liters per minute oxygen supplementation per nasal canula (tubing inserted into nostrils) as needed for shortness of breath or difficulty breathing.	01950		

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01950	Continued From page 19 R5's record lacked written instruction on when to remove the oxygen once applied and when to call the registered nurse (RN). On September 14, 2022, at approximately 10:30 a.m., director of nursing (DON)-F confirmed R5's record did not have specific instruction on oxygen removal and instructions of when the unlicensed personnel (ULP) would notify the RN. The licensee's Treatment or Therapy Management Services policy dated July 20, 2020, indicated RN would document specific resident instructions relating to the treatment or therapy, and document procedures for notifying an RN or appropriate licensed health professional when a problem arose with treatment or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.	02040		

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02040	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On September 14, 2022, approximately from 10:30 a.m. to 1:55 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-E and the environmental services director (ESD)-G. On September 14, 2022, at approximately 2:30 pm, a documentation review and interview were performed with the LALD-E and the ESD-G on the hazard vulnerability or safety risk assessment for the memory care physical environment. 1) Review of the plan documentation indicated the licensee had not performed a site-specific safety risk assessment on and around the property to identify vulnerabilities to protect the	02040		

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02040	Continued From page 21 memory care residents from harm. This finding was evident as the documentation provided did not include site-specific vulnerability content on safety risk assessment on and around the property. 2) Review of the plan documentation indicated the licensee did not identify mitigations to protect memory care residents from harm. Prevention measures or mitigations must be developed and documented in the plan to address all potential hazard vulnerabilities for this property. On September 14, 2022, at approximately 2:45 p.m., during the exit interview, the LALD-E and the ESD-G acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02290 SS=D	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee limited the rights of one of one resident (R7) reviewed when the licensee required the residents or their representatives to sign a risk agreement waiving the licensee's liability regarding the use of bed rails.	02290		

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NEW PERSPECTIVE - WOODBURY	2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125

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02290	Continued From page 22 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). R7's diagnoses included atherosclerotic heart disease (coronary arteries narrowed due to plaque formation). On September 13, 2022, at 8:10 a.m., the surveyor observed a bed rail on the right side near the head of R7's bed. The bed rail was a U-shaped bar which was secured between the mattress and box spring. R7 stated he used the bed rail to get into and out of the bed. R7's Negotiated Risk Agreement dated December 16, 2021, included "resident hereby agrees and instructs their designated representative, estate, estate representative and heirs to release, indemnify, and hold harmless the Community and its affiliates, directors, officers, employees, representatives, attorneys, and agents from any and all costs, expense, damages, injuries, losses, fines, penalties, or other liabilities arising out of or in connection with the subject matter of this Agreement and the decisions made by Resident or Resident's Legal Representative. Resident agrees that any renegotiation or termination of this Agreement shall not render the release or indemnify provided above ineffective as to any liability incurred by Community now or in the future arising out of or in connection with the subject matter of this	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31733	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WOODBURY	2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02290	Continued From page 23 Agreement. Resident desires that this release of liability and indemnification begin on the date and year first above mentioned and continues until the end of time, holding their heirs to its terms as stated herein." On September 14, 2022, at 9:10 a.m., director of nursing (DON)-F verified the risk agreement was signed by R7 and contained language waiving the licensee's liability related to bed rail use by R7. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290		
03000 SS=F	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31733	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WOODBURY	2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125

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03000	Continued From page 24 provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for one of five residents (R2). The facility was aware of the incident but did not report the incident to the Minnesota Adult Abuse Reporting Center (MAARC). This practice resulted in a level two violation (a violation that did not harm a resident's health or	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31733	A. BUILDING: _____ B. WING _____	09/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW PERSPECTIVE - WOODBURY	2195 CENTURY AVENUE SOUTH WOODBURY, MN 55125

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03000	Continued From page 25 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 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). The findings include: R6 was admitted on March 25, 2021, with diagnoses which included disorientation, major depressive disorder, history of falling, and anemia. R6's Resident Service Agreement dated February 25, 2022, indicated R6 resided in the licensee's locked memory care unit and received Service Type: Safety: Elopement Risk as the licensee was to, "Ensure [R6] is redirected and remains in safe and secure setting at all times unless escorted by a team member or family member." R6's Progress Notes dated March 20, 2022, at 12:12 p.m., signed by the facility registered nurse (RN), indicated R6 was located in the main entrance of the facility outside of the locked memory care unit at 7:30 a.m. without an escort or family member. R6 was escorted back to the secured memory care unit and the progress note read, "All the exits were promptly checked and confirmed in working order. Prior to finding [R6] outside the main doors, staff had helped [R6] sit down with a cup of coffee in the dining room. Management to follow-up today by checking security footage." No progress note indicated management completed follow-up or reviewed the events surrounding R6's elopement from the secured memory care unit.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31733	A. BUILDING: _____ B. WING _____	09/15/2022

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03000	Continued From page 26 On September 13, 2022, at approximately 2:00 p.m., a request for the incident report or MAARC report related to R6's elopement was made by the survey team. Director of Nursing (DON)-F stated an incident report or MAARC report was not created as the licensee believed R6 did not fully leave the facility and the situation was not considered an elopement. DON-F acknowledged R6 was required to reside in the licensee's locked memory care unit for R6's safety due to their cognition deficits. The licensee's Missing Resident and Elopement policy dated November 5, 2021, indicated the licensee would complete an incident report for all elopements and "file a report to the appropriate state agency if it is determined that a resident eloped, defined as a secured dementia unit resident leaving the secured dementia unit." The licensee's Accidents, Incidents, and Unusual Occurrences policy dated November 5, 2021, read when an incident report is filed, the licensee would, "When required by law, report to the state by filing a Minnesota Adult Abuse Reporting Center VA-CEP Report." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

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

Type: Full
Date: *09/13/22*
Time: 13:31:05
Report: 1023221167

Food and Beverage Establishment Inspection Report

Location:
New Perspective - Woodbury
2195 Century Avenue South
Woodbury, MN55125
Washington County, 82

Establishment Info:
ID #: 0039310
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514591400
ID #:

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

The following orders were issued during this inspection.

4-600 Cleaning Equipment and Utensils

4-602.11C ** Priority 1 **

MN Rule 4626.0845C Clean food-contact surfaces of equipment and utensils used for TCS foods, at least every 4 hour.

OPERATOR STATED PREP TABLE CUTTING BOARD USED TO PREP FOOD ONLY CLEANED ONCE PER DAY. IF USED AS A TCS FOOD CONTACT SURFACE CUTTINGS BOARDS MUST BE WASHED/RINSED/SANITIZED EVERY 4 HOURS.

Comply By: 09/13/22

2-100 Supervision

2-102.12AMN

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

NO CFPM EMPLOYED AT FACILITY BUT STAFF WENT TO FOOD SAFETY CLASS. INCLUDED CFPM APPLICATION WITH REPORT.

Comply By: 09/13/22

4-500 Equipment Maintenance and Operation

4-501.12

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

PREP TABLE CUTTING BOARD SCORED. REPLAIR/REPLACE TO PREVENT FOOD DEBRIS ACCUMULATION.

Comply By: 09/13/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit
Location: DISH MACHINE (REPAIRED)
Violation Issued: No

Food and Equipment Temperatures

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

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

Process/Item: Hot Hold/SOUP
Temperature: 153 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS ANNA BOHNEN. INSPECTION CONDUCTED IN PRESENCE OF ASHLEY WEYANDT AND NICOLE WEBER, THE PERSONS IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

THIS FACILITY CONSISTS OF A MAIN KITCHEN ON THE FIRST LEVEL WITH A TYPE I HOOD/ANSUL, A TYPE II HOOD FOR DISH MACHINE, AND A PREP SINK. FOOD SERVICE STAFF ARE EMPLOYEES OF FACILITY.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FOOD COOLING METHODS
- TIME AS A PUBLIC HEALTH CONTROL
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

DOCUMENTS ON THE FOLLOWING TOPICS WERE INCLUDED WITH INSPECTION REPORT:
- EMPLOYEE ILLNESS TRACKING
- SAMPLE VOMIT CLEAN UP PROCEDURE
- SAMPLE HANDWASHING SIGN
- FOOD COOLING VERIFICATION

Food and Beverage Establishment Inspection Report

- HIGH RISK POPULATION REQUIREMENTS

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

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 1023221167 of 09/13/22.

Certified Food Protection Manager: NICOLE WEBER

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
ASHLEY WEYANDT
PERSON IN CHARGE

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