DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 30, 2022

Administrator
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal, MN 55429

RE: Project Number(s) SL24780015

Dear Administrator:

On April 7, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 8, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

Electronically Delivered
January 28, 2022

Administrator
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal, MN 55429

RE: Project Number(s) SL24780015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 8, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

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

Please address your cover letter for general reconsideration requests to:
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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24780	A. BUILDING: _____ B. WING _____	12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMAZING LOVE ASSISTED LIVING	5724 BASS LAKE ROAD CRYSTAL, MN 55429

(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 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: SL24780015 On December 7, 2021, through December 8, 2021, 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 16 residents receiving services under the provider's Assisted Living license. The immediate correction order tag identification 0110, identified on December 7, 2021 has been corrected as of December 8, 2021. No further action required.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND	

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0 000	Continued From page 1	0 000	REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD)-C was listed as the Director of Record for the licensee and had applied to be shared director for all the company's other licenses. This had the potential to affect all the licensee's residents, staff, and visitors. This resulted in an immediate correction order. 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: LALD-C started employment on May 21, 2019, under the licensee's comprehensive home care license and began providing assisted living services on August 1, 2021.	0 110	The immediate correction order tag identification 0110, identified on December 7, 2021 has been corrected as of December 8, 2021. This was confirmed by phone conversation between NP/NM-D and evaluation supervisor and email from BELTSS. No further action required.	

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0 110	Continued From page 2 On December 7, 2021, at approximately 1:15 p.m.., during the entrance conference, a request was made to see LALD-C 's Minnesota Board of Executives for Long-Term Services and Support (BELTSS) license. On December 7, 2021, at approximately 1:30 p.m., the BELTSS website indicated LALD-C currently held a LALD license, but LALD-C was not listed as the Director of Record for any licensee and was not listed as a shared director. On December 7, 2021, at approximately 1:15 p.m., during an interview, nurse practitioner/nurse manager (NP/NM)-D stated LALD-C was the LALD for the licensee, and she did not know if she was the shared director for all the company's other licenses. A policy related to a Licensed Assisted Living Director was requested, but not provided. No further information was provided Time Period to Correct: IMMEDIATE On December 8, 2021, immediacy removed as confirmed by phone conversation between NP/NM-D and evaluation supervisor and email from BELTSS.	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;	0 470		

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0 470	Continued From page 3 (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop or implement a staffing plan to determine its staffing level. This had the potential to affect all 13 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 470		

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0 470	Continued From page 4 The findings include: The licensee held an assisted living license, effective August 1, 2021. The licensee was licensed for a resident capacity of 26 residents and had a current census of 13 residents. During the entrance conference on December 7, 2021, at approximately 2:30 p.m., nurse practitioner/nurse manager (NP/NM)-C explained how the licensee staffed its building. NP/NM-C questioned what a staffing plan was. The surveyor explained what a staffing plan was and NP/NM-C stated the licensee did have a staffing plan and would bring a copy for review. The licensee's Staffing policy, dated August 1, 2021, indicated the clinical nurse supervisor would prepare and implement a twenty-four (24) hour daily staffing plan that would ensure adequate staffing to meet resident needs at all times. The licensee's staffing plan was request but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

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0 480	Continued From page 5 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all thirteen (13) residents in the Assisted Living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated December 7, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one	0 480		

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0 480	Continued From page 6 (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs for two of two residents (R1 and R2) with records reviewed.	0 490		

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0 490	Continued From page 7 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: During observations on December 7, 2021, and December 8, 2021, no activities were planned or offered for the licensee's residents. On December 7, 2021, at approximately 10:45 a.m., R1 sat in the common area on a couch with his head bent down toward his knees. During interview with R1 on December 7, 2021, at approximately 10:45 a.m., R1 stated that he was not aware of any calendar indicating activities available for residents. R1 also stated that staff did not provide any activities other than taking residents to the store when the residents would ask or staff would play cards with residents if the residents requested. On December 7, 2021, at approximately 2:00 p.m., Nurse Practitioner/nurse manager (NP/NM)-C stated the licensee provided daily activities to all residents and that the licensee did have a calendar listing all the activities available to residents. NP/NM-C stated she would provide a copy of the activity calendar. The licensee lacked policies related to a daily program and social activities noted in the Assisted Living Licensure requirements effective	0 490		

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0 490	Continued From page 8 August 1, 2021. The licensee's activity calendar was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19. The licensee also failed to ensure staff wore eye protection while working. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 510		

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0 510	Continued From page 9 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 Minnesota Department of Health (MDH) guidance titled, "COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Settings," dated April 23, 2021, indicated heath care workers (HCW) with face-to-face contact with COVID-19 negative clients were to wear eye protection. On December 7, 2021, at approximately 9:35 a.m., unlicensed personnel (ULP)-B greeted the surveyor at entrance, wearing only a face mask for PPE. ULP-B was not wearing eye protection. ULP-B allowed the surveyor to enter after obtaining temperature and asking about symptoms of COVID-19. During an observation on December 7, 2021, at approximately 10:10 a.m., ULP-D wore a face mask placed over the mouth with the nose exposed. On December 7, 2021, at approximately 12:45 p.m, Nurse Practitioner/nurse manager (NP/NM)-C entered the main door and was screened for COVID-19 symptoms and told to check temperature with electronic thermometer placed on wall. NP/NM-C was wearing a face mask and no eye protection. During the exit conference on December 9, 2021, at approximately 10:00 a.m., NP/NM-C stated she	0 510		

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0 510	Continued From page 10 was not aware staff were still required to wear eye protection while providing care to residents. NP/NM-C stated the licensee did have eye protection available for staff and would immediately ensure staff begin to wear eye protection. The licensee's Infection Control policy, dated August 1, 2021, did not contain any information in regards to COVID-19 or personal protective equipment requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management	0 580		

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0 580	Continued From page 11 activities relevant to the size and services provided by the assisted living provider. 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: During the entrance conference on December 7, 2021, at approximately 1:30 p.m., Nurse Practitioner/nurse manager (NP/NM)-C stated the licensee did have regular quality management meetings and could provide documentation noting the agenda and any notes taken during the meetings. On December 7, 2021, at 3:00 p.m., NP/NM-C provided copies of the licensee's staff meeting agendas and meeting minutes. After reviewing meeting notes, the surveyor asked NP/NM-C if she could provide the licensee's quality management meetings documentation, as the notes that NP/NM-C provided were specifically for the staff and did not contain content related to quality management. NP/NM-C then stated she would find documentation and provide it to the surveyor. The licensee's Quality Improvement policy, dated August 1, 2021, indicated the licensee had established a quality improvement program based on the licensee's size and appropriate to the type of services provided in order to assure	0 580		

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	24780	A. BUILDING: _____ B. WING _____	12/08/2021

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0 580	Continued From page 12 that effective, comprehensive, and appropriate plans are operational for all residents within the organization. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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 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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with	0 650		

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0 650	Continued From page 13 the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained training and competency evaluations for one of one unlicensed personnel (ULP)-B who performed delegated tasks. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of February 17, 2018. ULP-B's record lacked any documentation that training and competency testing in delegated tasks had been completed. During an interview on December 7, 2021, at approximately 11:10 a.m., ULP-B stated the registered nurse (RN) had provided all training and orientation to ULP-B at the time of hire. ULP-B said she also had online training for dementia. During the exit conference on December 9, 2021, at 10:00 a.m., Nurse Practitioner/nurse manager (NP/NM)-C stated all staff are trained by a RN and must return demonstrate competency for delegated tasks. NP/NM-C stated she would	0 650		

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0 650	Continued From page 14 provide ULP-B's training records for review. The license's Staff Competency policy, August 1, 2021, indicated ULPs would not be allow to work for licensee until they had successfully completed a written and demonstration competency evaluation. ULP-B's demonstrated delegated task competency records were requested but not provided. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	0 650		
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 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	0 680		

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0 680	Continued From page 15 available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an emergency disaster plan (EDP) containing all the requirements outlined in Appendix Z and posted prominently. 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: During the entrance conference on December 7, 2021, at approximately 2:00 p.m., Nurse Practitioner/nurse manager (NP/NM)-C stated the licensee had an emergency EDP binder. The licensee's EDP lacked the following components: - post an emergency disaster plan prominently - post emergency exit diagrams on all floors - program patient population - subsistence needs for staff and residents -tracking staff and residents -volunteer policies and procedures -roles under a waiver declared by Secretary -communication plan	0 680		

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0 680	Continued From page 16 -sharing information occupancy needs -family notifications - blank form, no forms in resident records -emergency prep testing requirements - blank test form in binder - no tests in staff training records During an interview with R1 on December 7, 2021, at 10:30 a.m., R1 stated he did not receive any emergency evacuation information. During intervew on December 8, 2021 at approximately 9:05 a.m, NP/NM-C stated she was not aware there wasn't an emergency evacuation plan posted in the licensee's building or that the licensee did not have the most up to date documentation regarding the licensee's emergency plan. NP/NM-C stated she did believe that all staff and all residents had been educated on the licensee's emergency evacuation plan but was unaware there was no documentation showing they recieved the education. The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that would disrupt services. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 17 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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	0 780		

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0 780	Continued From page 18 of the residents). The findings include: On December 7, 2021, between 12:05 p.m. and 12:50 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During the tour, the following observations were made: 1. Two bedroom smoke alarms were tested and did not activate any of the other smoke alarms in the Olivia House building. During tour interview with ULP-C, they confirmed that these smoke alarms were not interconnected. They explained that this building was not currently being used by residents for sleeping, only for showers. 2. The kitchen smoke alarm in Emanuel House was chirping, ULP-C confirmed during tour interview that this smoke alarm required maintenance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation	0 800		

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0 800	Continued From page 19 with regard to the health, safety and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 December 7, 2021, between 12:05 p.m. and 12:50 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C. During facility tour, survey staff observed: 1. Hot water was not provided by the plumbing fixtures in Emanuel House. Faucets in first floor bathrooms only provided cold water when checked by survey staff. ULP-C explained during tour interview that the water heater was broken. They explained that a repair company had been contacted and that residents were using the shower in Olivia House. 2. A ceiling tile was water stained and sagging in the first floor half bathroom of Emanuel House. ULP-C explained during tour interview that a water spill on the second floor had damaged the ceiling and that this tile required replacement. 3. There was a hole in the hallway ceiling on the second floor of Emanuel House. This hole measured approximately 20" x 30". ULP-C confirmed during tour interview that the hallway ceiling required repair. 4. There was a crack in the ceiling between the hallway and living room on the second floor of Emanual House. ULP-C confirmed during tour interview that the ceiling was damaged and required repair.	0 800		

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0 800	Continued From page 20 5. A stairway handrail was loose on the second floor of Emanuel House. This stairway was used to access the front door from the living room . ULP-C stated during tour interview that she was not aware this handrail was loose and confirmed that it required repair. 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.	0 810		

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0 810	Continued From page 21 (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 observation, record review and interview, the licensee failed to provide the required training and plans for fire safety and evacuation. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 December 7, 2021 between 12:05 p.m. and 12:50 p.m., survey staff toured the facility with unlicensed personnel (ULP)-C . It was observed that evacuation maps were not posted within the facility. On December 7, 2021 at 1:15 p.m., records were provided for review by ULP-C. On December 7, 2021, between 1:15 p.m. and 1:40 p.m., records were reviewed by survey staff. These records included an Emergency Preparedness Manual dated 07-2021 and a Fire Safety Policy dated 08-01-2021. No employee or resident training records were provided for fire safety and evacuation. No copies of completed	0 810		

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0 810	Continued From page 22 evacuation drill logs were provided. 1. The licensee failed to provide documentation of annual fire safety and evacuation training for residents. 2. The licensee failed to provide documentation of staff training for fire safety and evacuation. 3. The licensee failed to provide documentation of completed evacuation drills. The fire drill log in the Fire Safety Policy was blank. 4. The fire safety and evacuation plans found within the Emergency Preparedness Manual did not include the location and number of resident sleeping rooms. The facility diagram on page 1.9 was blank. The evacuation plans on page 1.10 were blank. On December 7, 2021, between 1:55 p.m. and 2:10 p.m., ULP-C confirmed during exit interview that the licensee failed to provide evacuation maps. ULP-C explained that training records and logs were kept in the building across the street. ULP-C further explained that new staff complete Edu-Care for fire safety and evacuation training. ULP-C stated that a follow-up email would be sent to survey staff on December 8, 2021 with examples of staff and resident training along with copies of evacuation drill logs. As of December 13, 2021, a follow-up email had not been received by survey staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or	01440		

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01440	Continued From page 23 therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing delegated tasks within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-B) with employee record reviewed. 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 an isolated scope (when one or a limited number of clients are affected or one or a	01440		

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01440	Continued From page 24 limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of February 17, 2018. ULP-B's employee record lacked documentation of direct supervision to verify that the work was performed competently and to identify problems and solutions to address issues relating to ULP-B's ability to provide the services. During interview on December 8, 2021, at approximately 10:00 a.m., Nurse Practitioner/nurse manager (NP/NM)-C stated she was not aware ULP-B did not have any documentation of supervisory evaluations of delegated tasks in ULP-B's employee record. NP-C stated she would provide this documentation. The licensee's policy on supervision was requested, but not provided. ULP-B's supervisory evaluations of delegated tasks was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
625 Robert St. N.
St. Paul, MN 55164-0975
651-201-4500

HFID 24780
SL2478 0015

Type: Full
Date: *12/07/21*
Time: 13:45:00
Report: 1022211253

Food and Beverage Establishment Inspection Report

Location:
Amazing Love Assisted Living
5724 Bass Lake Road
Crystal, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038508
Risk:
Announced Inspection: No

License Categories:

Expires on: 07/16/22

Operator:

Phone #: 7635613434
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED RAW SHELL EGGS STORED ABOVE READY TO EAT FOODS IN THE SINGLE DOOR REFRIGERATOR IN THE MAIN KITCHEN. COMPLY WITH ABOVE RULE. COS: THE PIC RELOCATED THE RAW SHELL EGGS TO AN APPROVED LOCATION.

Comply By: 12/07/21

2-500 Responding to contamination events

2-501.11 ***** Priority 2 *****

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

INSPECTOR WAS UNABLE TO VIEW A VOMIT/FECAL CLEAN UP PROCEDURE AT THE TIME OF THE INSPECTION. EDUCATION WAS PROVIDED ON HOW TO CLEAN UP.

Comply By: 12/07/21

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

A SIGN WAS PRESENT AT THE DISH WASHING SINK STATING THIS SINK IS MEANT FOR HANDWASHING. HOWEVER, PIC STATED THAT THIS IS INDEED A DISH WASHING SINK.

Comply By: 12/07/21

Type: Full
Date: *12/07/21*
Time: 13:45:00
Report: 1022211253
Amazing Love Assisted Living

Food and Beverage Establishment Inspection Report

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE UPRIGHT SINGLE DOOR REFRIGERATOR AND THE TWO DOOR REFRIGERATOR HAD AMBIENT TEMPERATURES OF 51°F AND 48°F, RESPECTIVELY. REPAIR OR REPLACE COOLERS SUCH THAT THEY HOLD TCS FOODS AT OR BELOW 41°F.

Comply By: 12/07/21

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

OBSERVED FOOD RESIDUE ON AND AND INSIDE MULTIPLE CABINET SURFACES.

Comply By: 12/07/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.112

MN Rule 4626.1570 Remove dead or trapped birds, insects, rodents, and other pests from the premises.

OBSERVED FRUIT FLIES IN THE KITCHEN AREA.

Comply By: 12/07/21

Food and Equipment Temperatures

Process/Item: Single Door Refrigerator
Temperature: 51 Degrees Fahrenheit - Location: Mozzarella held for 4+ hrs
Violation Issued: Yes

Process/Item: Single Door Refrigerator
Temperature: 49 Degrees Fahrenheit - Location: Bologne held for 4+ hrs
Violation Issued: Yes

Process/Item: Single Door Refrigerator
Temperature: 48 Degrees Fahrenheit - Location: Rice pudding cups held for 4+ hrs
Violation Issued: Yes

Process/Item: Single Door Refrigerator
Temperature: 48 Degrees Fahrenheit - Location: Ambient temperature
Violation Issued: Yes

Process/Item: Two Door Refrigerator
Temperature: 45 Degrees Fahrenheit - Location: 2% milk held for 4+ hrs
Violation Issued: Yes

Process/Item: Two Door Refrigerator
Temperature: 48 Degrees Fahrenheit - Location: Ambient temperature
Violation Issued: Yes

Food and Beverage Establishment Inspection Report

Process/Item: Upstairs Refrigerator
Temperature: 39 Degrees Fahrenheit - Location: Bologne
Violation Issued: No

Process/Item: Upstairs Refrigerator
Temperature: 36 Degrees Fahrenheit - Location: Sliced ham
Violation Issued: No

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

1. Inspection was conducted with Helen Osonowo, Nurse Provider at the establishment, and Elyse Jones, Nursing Evaluator with MDH.
2. Discussed with PIC the need for an employee illness log for recording illnesses other than Covid-19.
3. Establishment has two kitchens. One main one and one upstairs. Upstairs kitchen is only used for storage of cold food and no cooking.
4. Kitchen area has cabinets, counter tops and floor in disrepair.
5. Kitchen countertops are grouted tile.
6. No base coving was available on any parts of the flooring.
7. Establishment reheats pre-cooked food frozen food from the grocery store and does not prepare raw meat.
8. Establishment did not have hot water at the time of the inspection.
9. Establishment has a dishmachine with a sanitizing feature. It is a Samsumg model: DW80R7060US.
10. Education was provdied on chemical sanitization using chlorine.
11. Establishment uses Orkin as a pest control service. Last service was 10/28/2021. Recommend monthly service for a multi unit establishment.

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 1022211253 of 12/07/21.

Certified Food Protection Manager Adeyemi T. Osonowo

Certification Number: FM85522 Expires: 08/25/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
Helen Osonowo
Nurse Provider

Signed: _____
Inspector Number 1022

651-201-4500
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