DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 6, 2021

Administrator
Okalee of Medina
4350 Chippewa Court
Medina, MN 55340

RE: Project Number(s) SL35700015-1

Dear Administrator:

On December 1, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 23, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is back in 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,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

Electronically Delivered

October 22, 2021

Administrator
Okalee of Medina
4350 Chippewa Court
Medina, MN 55340

RE: Project Number(s) SL35700015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 23, 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 Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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), immediate fine imposition is authorized for both surveys and investigations conducted. 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.

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. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

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

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

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

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

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

(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 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: SL35700015 On September 20, 2021, through September 23, 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 57 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 of the licensee's 57 current 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 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	0 480		

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0 480	Continued From page 2 and Beverage Establishment Inspection Report, dated September 22, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain an infection control program related to COVID-19. This had the potential to affect all 57 residents and facility 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, 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		

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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). COVID-19 RESIDENT SCREENING AND MONITORING The licensee lacked evidence all assisted living residents were monitored for oxygen saturation levels and screened for COVID-19 symptoms at least daily. The MDH guidance document titled, COVID-19 Toolkit, Information for Long Term Care Facilities, dated March 8, 2021, indicated all residents should be actively screened for fever and symptoms consistent with COVID-19 at least daily. If a pulse oximeter was available, daily pulse oximetry screening was recommended with charting of clinical measurements and symptoms for each resident. On September 20, 2021, at 2:10 p.m., the Regional Director of Operations (RDO)-E stated the "independent living" residents or residents with a contract for housing only, were not screened daily. There were no records to indicate evidence of daily COVID-19 screening and monitoring, including no pulse oximetry readings or symptom screening. On September 23, 2021, at 2:45 p.m., the RDO-E discussed the difficulty of screening residents with a contract for housing only daily, as the assisted living facility staff were not aware of any of their schedules and did not have a process to track their activities. RDO-E confirmed the licensee lacked any type of process to daily monitor the residents with a contract for housing only for COVID-19 symptoms as required. RDO-E confirmed none of the residents with a contract for housing only were screened daily.	0 510		

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0 510	Continued From page 4 The licensee's COVID-19 protocol (formerly Phase 2 and Phase 3)-AL [assisted living] Infection control policy, dated September 17, 2020, noted only that all residents who received home care services would have their temperatures and oxygen saturation levels checked daily along with symptoms monitoring. The policy lacked any language related to COVID-19 screening of residents with a contract for housing only within the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 620 SS=D	144G.42 Subd. 6 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 observation, interview and record review, the licensee failed to ensure an allegation of suspected maltreatment was reported to Minnesota Adult Abuse Reporting Center (MARRC) timely for one of one resident (R1) with an injury of unknown origin reviewed. This practice resulted in a level two violation (a	0 620		

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0 620	Continued From page 5 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: An initial MAARC reported dated August 23, 2021, at 5:37 p.m. noted on the morning of August 21, 2021, R1 was observed with eye discoloration (unknown origin). R1's assessment dated August 23, 2021, described R1 as a resident with a contract for housing only, and independent with bathing, dressing and grooming with cues and/or set-up. A SLUMS (screening tool for dementia developed by Saint Louis University geriatricians that identifies cognitive problems-a score below 20, indicative for dementia) exam noted R1 scored 9 out of 30. On September 21, 2021, at 10:45 a.m., R1 was observed to have an area of dark blue discoloration below the right eye, smaller than one inch in length and approximately 1/2 inch width. When asked how the discoloration occurred, R1 reported it had something to do with a friend, but it was "over" and "done" and did not want to discuss it further. A MAARC report dated August 23, 2021, noted discoloration under R1's right eye that measured 1 cm (centimeter) x 2 cm red purple area with some yellowing outer brow. The report indicated the discoloration was initially observed on the	0 620		

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0 620	Continued From page 6	0 620		

morning of August 21, 2021. When staff questioned how it occurred, R1's story changed from an unwitnessed fall to someone hitting her. "After further questioning she said it was another resident then changed her story to 'last night.' "

The facility's internal investigation lacked dates, times and names of individuals who were interviewed regarding the discoloration. The documentation consisted of a narrative summary dated August 23, 2021, with additional notes dated August 31, 2021, and September 7, 2021. The investigation was completed by Registered Nurse (RN)-D and the administrator.

On September 20, 2021, at 3:40 p.m., R1's family member (F)-M stated R1 moved into an "independent apartment" on August 16, 2021, and was transferred to the memory care unit on August 18, 2021. F-M stated R1 reported she was "punched" during an altercation with an individual around or during the time of the move. (During an interview with R1 on September 22, 2021, at 10:45 a.m. R1 reported she had no recollection of a move).

On September 22, 2021, at 10:45 a.m., RN-D stated when she came to work on Monday (August 23, 2021) she was informed of R1's "bruise." RN-D verified the incident was not reported to MAARC timely because staff thought it had been previously reported. RN-D stated as time progressed, the bruising and swelling around R1's eye increased. (However, there was no documentation of the progression-which was verified on the same date and time). RN-D stated R1 thought she (RN-D) hit her and caused the bruise. The internal investigation noted video footage was reviewed, which noted R1 did not have any bruising on Friday (August 20, 2021),

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0 620	Continued From page 7 and the bruising was observed on Saturday (August 21, 2021). RN-D verified she had assisted in physically moving R1 to the memory care unit on August 18, 2021. The Abuse Prohibition-AL-MN policy dated February 2019, noted employees were directed to immediately report suspected/alleged violations of maltreatment to the Registered Nurse. "Report all alleged violations and substantiated incidents immediately to the state agency as required." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement and individual abuse prevention plan that included an individualized review or assessment of the	0 630		

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0 630	Continued From page 8 person's susceptibility of abuse by another individual, including other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse for one of four residents (R1) with records reviewed. 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: Record review, dated August 22, 2021, noted R1 was admitted on August 16, 2021, under a housing only contract, did not receive any assisted living services; and was transferred to the memory care unit on August 18, 2021. R1 lacked the development of an individual abuse prevention plan until August 23, 2021, (eight days after admission) and after R1 sustained an injury of unknown origin on August 21, 2021. R1's abuse prevention plan completed on August 23, 2021, lacked identification and specific measures related to the injury of unknown origin. A MAARC report dated August 23, 2021, noted R1 had discoloration under the right eye that measured 1 cm (centimeter) x 2 cm red purple area with some yellowing outer brow. The report indicated the discoloration was initially observed on the morning of August 21, 2021, and when staff questioned R1 how it occurred, the story changed from an unwitnessed fall to someone	0 630		

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0 630	Continued From page 9 hitting her. On September 22, 2021, at 10:45 a.m., Registered Nurse (RN)-D stated she had completed an assessment, including an individual abuse prevention plan on August 18, 2021; however, she forgot to save the computerized assessment, and it was subsequently lost. The Individual Abuse Prevention Plan policy dated August 1, 2021, noted an individual abuse prevention plan was developed for each assisted living resident. Assisted living residents who received nursing services would have an individual abuse prevention plan based upon the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=E	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;	0 650		

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0 650	Continued From page 10 (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 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 observation, interview and record review, the licensee failed to maintain current employee records for each individual contractor providing home care services for one of one contracted unlicensed personnel (ULP-D) and failed to ensure an annual performance evaluation was completed for one of one unlicensed personnel (ULP-C) with records reviewed. 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 situation has occurred repeatedly; but is not found to be pervasive).	0 650		

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0 650	Continued From page 11 The findings include: During the entrance conference on September 20, 2021, at 9:30 a.m., the Registered Nurse (RN)-B and the Regional Director of Operations (RDO)-E stated the licensee used three supplemental staffing agencies to meet their staffing needs for unlicensed personnel. ULP-D Record review of ULP-D's employee record indicated ULP-D started providing home care services via a contracted supplemental staffing agency on March 23, 2021. ULP-D's record lacked an employee record with the required contents to include: -evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; -records of orientation, required annual training and infection control training, and competency evaluations; -current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; -for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and -documentation of the background study as required under section 144.057. On September 21, 2021, at 7:00 a.m., ULP-D was observed in the memory care unit assisting residents with personal care services. ULP-D stated she was current on the nursing assistant registry and had approximately a 30 minute orientation with a RN when she initially came to the facility.	0 650		

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0 650	Continued From page 12 On September 23, 2021, at 10:00 a.m., RN-B and the administrator verified the lack of employee records for all contracted staff who provided services for the facility. RN-B and the administrator stated the supplemental nursing agencies guaranteed staff had all the necessary training, orientation and health screening. RN-B and the administrator stated they would obtain records of orientation, certification, health screening and background study from the staffing agencies. ULP-C ULP-C's employee record lacked evidence of documentation of an annual performance review that identified areas of improvement needed and training needs. ULP-C had a hire date of May 8, 2020, to provide direct care services to the licensee's residents. On September 21, 2021, from 6:35 a.m. to 8:20 a.m., ULP-C was observed administering prescribed medications to multiple residents (R), including R3 and R4. On September 23, 2021, at approximately 11:20 a.m., RN-B verified ULP-C's record lacked evidence of an annual performance review. The licensee's undated Content of Employee Records-AL [Assisted Living] policy noted the licensee maintained current records of each paid employee and each individual contractor providing home care services. In addition, the policy noted annual performance reviews, which identified areas of improvement and training needs were also included in the employee record. No further information was provided.	0 650		

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0 650	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis (TB) infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC). In addition, the licensee failed to ensure one of two employees unlicensed personnel (ULP-C) completed baseline TB screening at date of hire with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 14 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB facility risk assessment dated December 12, 2019, was noted as low risk. ULP-C's record lacked evidence of baseline TB screening when hired on May 8, 2020. ULP-C's record Cassia TB Screening Tool dated May 8, 2020, (signed by ULP-C) noted a positive TB screening result dated March 2018 on the self-report form. The record also indicated a negative chest x-ray, dated May 11, 2020, "not consistent with TB." ULP-C's record lacked any evidence of a positive TB screen or medical exam following the chest x-ray. On September 23, 2021, at 11:25 a.m., Registered Nurse (RN)-B confirmed ULP-C's record lacked evidence of a baseline TB screening, either a TB serum test or two-step skin test (TST) at the time of hire. RN-B stated she was unaware the employee record would also require evidence of a positive TB screen prior to the chest x-ray; and confirmed this procedure was missed at hire date. The Tuberculosis Prevention and Screening policy dated May 7, 2019, noted employees with written documentation of previous positive tuberculin skin test (TST) or blood test need TST documentation to include the exact date, the induration and interpretation. If the past	0 660		

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0 660	Continued From page 15 documentation cannot be located, documentation of a history of infection with TB by a physician is acceptable. In addition documentation of a negative chest x-ray showing no active disease dated after the positive TST or blood test must be obtained prior to starting work. The policy lacked procedures for a medical evaluation, following a past-positive TST or blood test and chest x-ray. The licensee's TB prevention and control policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	0 680		

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0 680	Continued From page 16 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 interview and record review, the licensee failed to ensure the facility provided and posted building emergency exit diagrams as required. 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 September 20, 2021, at approximately 10:00 a.m., a request was made to view the licensee's disaster and emergency preparedness plan, which was provided and later reviewed by the surveyor. During a facility tour with the administrator on September 20, 2021, at approximately 11:30 a.m., that included three floors of resident living units, and one lower level secured memory care unit, there were no observed building emergency exit diagrams signage posted or information regarding the licensee's location of emergency exits. The licensee had available to all residents,	0 680		

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0 680	Continued From page 17 staff, and visitors a well developed Emergency Preparedness Plan at their main entry. On September 22, 2021, at 3:00 p.m., the administrator stated the licensee was aware of the posting requirement, and the building architect was supposed to have provided emergency exit diagrams; however, had not yet completed the task. The administrator confirmed the licensee's emergency disaster preparedness plan lacked evidence of the required posting of emergency exit diagrams throughout the building (each of the four floors) available for all residents. The Emergency Preparedness Program/Plan policy dated July 1, 2021, lacked procedures related to ensure building emergency exit diagrams were provided to each resident and posting the diagrams on each floor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730		

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0 730	Continued From page 18 allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of incidents involving the	0 730		

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0 730	Continued From page 19 resident and actions taken in response to the needs of the resident for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record consisted of multiple late entries and lacked a chronological description of what happened and when it happened, including specified dates and times. Entries dated August 16, 17, and 18, 2021, were documented on August 22, 2021, with some entries documented after 11:00 p.m. It was difficult to ascertain exactly when the incidents occurred, as the documentation was narrative and completed six days after the occurrence. This was verified with the Registered Nurse (RN)-B on September 22, 2021, at 10:45 a.m. R1's record lacked documentation of R1's eye discoloration, when it was initially observed, and ongoing monitoring of the eye. The record lacked documentation that R1's family was updated regarding incidents, and R1's injury of unknown origin. On September 22, 2021, at 10:45 a.m., RN-D stated as time progressed, the bruising and swelling increased around the eye; and verified R1's record lacked documented evidence of the	0 730		

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0 730	Continued From page 20 right eye physical changes. R1's record lacked documentation of incidents involving R1, including actions in response to the needs of R1. On September 22, 2021, at 10:45 a.m. the administrator reported R1 went into another resident's apartment while family members were moving furniture out on or around August 17, 2021. According to the administrator, R1 sat on the sofa and verbalized it was her apartment. R1's record lacked documentation when this incident occurred and who had assisted R1 out of the other resident's apartment. On September 22, 2021, at 10:45 a.m. the administrator and RN-D verified the lack of documentation in R1's record related to the incident noted above. R1's record lacked documentation of "agitation," including what the behaviors consisted of on August 18, 2021, following a move to memory care unit, as well as why the provider recommended to the family not to visit R1. On September 20, 2021, at 3:40 p.m., R1's family member (F-M) alleged the facility would not allow the family to visit R1 in memory care because R1 was described as "agitated." On September 22, 2021, at 10:45 a.m., RN-D and the administrator stated R1 was not initially agitated, but became so later at around 4:30 p.m. or 5:00 p.m. on August 18, 2021. RN-D stated the provider did not prohibit the family from visiting, but described it as a recommendation. RN-D verified a lack of record documentation as	0 730		

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0 730	Continued From page 21 to what behaviors R1 exhibited on August 18, 2021, at 4:30 p.m. or 5:00 p.m. The Content of the Client Records-AL [Assisted Living] dated August 15, 2019, noted entries in the client record were current. The policy noted the record included incidents involving the client and actions taken in response to the needs of the client including reporting the appropriate supervisor or health care professional. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
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.	0 810		

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0 810	Continued From page 22 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure fire safety and evacuation plans were readily available to 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 client'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 clients). The findings include: On September 21, 2021, between 10:00 a.m. and 12:05 p.m. during a facility tour with the Housekeeping Supervisor (HS), it was observed there were no fire safety and evacuation plans posted in any of the rooms or corridors on any of the four facility residential floors. Between 12:05 p.m. and 12:40 p.m., an interview and review of the facility records were conducted	0 810		

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0 810	Continued From page 23 with the administrator regarding fire safety and evacuation plans and employee training. Based on this review, the records lacked evidence of a fire safety and evacuation plan. An interview conducted with the administrator indicated the facility's architect had completed a plan, and the facility had an electronic copy; however, the fire safety and evacuation plan had not been posted or distributed at this time. The administrator was aware fire safety and evacuation plans would play an important role in the ability of residents and staff to know what to do and how to evacuate the building in the event of a fire or emergency situation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01160 SS=D	144G.56 Subd. 2 Orderly transfer A facility must provide for the safe, orderly, coordinated, and appropriate transfer of residents within the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a safe, orderly, and coordinated transfer was provided for one of one resident (R1) who was transferred to the memory care unit. 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	01160		

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01160	Continued From page 24 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: Record review noted R1 was admitted on August 16, 2021, under a housing only contract, did not receive any assisted living services and was transferred to the memory care unit on August 18, 2021. On September 20, 2021, at 3:40 p.m., R1's family member (F)-M stated R1 moved into an "independent apartment" on August 16, 2021, and was transferred to the memory care unit on August 18, 2021. F-M stated R1 was assessed as "independent." F-M stated on August 18, 2021, the facility called and reported they were moving R1 to the memory care unit. According to F-M, the family drove from Edina to Medina after the call with the facility, and R1 had already been moved to the memory care unit. F-M reported most of the R1's items were removed from R1's apartment by the time they arrived. F-M alleged the facility would not allow family to visit R1 in memory care because R1 was described as "agitated." F-M stated the facility provided an option that they take R1 home with them, but did not offer other options, such as having a friend or family member stay with the resident or an outside agency to provide additional assistance. F-M indicated they were not happy with the move and felt they did not have any choices. F-M stated they thought everything was going well on August 17, 2021, and indicated they were surprised about R1's increased confusion as reported by the facility on August 18, 2021, which prompted the move.	01160		

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01160	Continued From page 25 R1's record included multiple late entries dated August 17 and August 18, 2021, regarding the reasons for moving R1 to the memory care unit. Notations included but not limited to the following (which were completed on August 22, 2021): - August 17, 2021, at 9:28 a.m. "tenant found wandering the halls looking for her apartment several times in the evening and several more times on overnight shift. She was found on 3rd and 2nd floor." The resident was brought to the dining room and seated with other residents and asked another resident if he could bring her car to her. "She found another resident in the hallway and said she was looking for her family and if she could find her car she would just drive to them. The resident pushed her pendant for staff to assist. When staff came to assist resident stated she was missing her purse, car and waiting for her family." - August 17, 2021, at 6:46 p.m. "Resident needed assistance locating her purse x 4 today all 4 times this was very close to her in plain sight. She also was looking for her cousin [name] who was coming to visit her." In addition, staff reported that R1 was packed to go home, and waiting for her cousin to pick her up. - August 18, 2021, at 11:33 a.m. noted the family was contacted regarding "confusion" observed and "explained to him the that only way I can keep her safe if [sic] to have her placed where there is more supervision." The family maintained the incidents were behavioral and "then explains times where she would go to her front yard, and stare and be confused that the neighbors would call him and would come and tell her to go back inside and 'straighten' her out and she would be	01160		

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01160	Continued From page 26 good for a while." [sic] According to the notation, the family gave approval to move R1 to the memory care unit. R1 was moved to the memory care unit without coordination with family members, without a reassessment upon admission to the unit, without current medication orders, or a medical evaluation to determine possible causal reasons for the increased memory difficulties. R1's "Admission Assessment" dated August 16, 2021, noted R1 was independent with activities of daily living, including bathing, dressing, and toileting. According to the assessment, R1 could not locate her medications. The vulnerability assessment was not completed and blank. A SLUMS examination (screening tool for dementia developed by Saint Louis University geriatricians that identifies cognitive problems-a score below 20, indicative for dementia) indicated a score of 11 out of 30. On September 22, 2021, at 10:45 a.m., Registered Nurse (RN)-D and the administrator stated R1 was not initially agitated, but became so later at around 4:30 p.m. or 5:00 p.m. RN-D stated they did not prohibit the family from visiting, but described it as a recommendation. RN-D verified she physically assisted R1's move to the memory care unit. RN-D stated a reassessment was completed on August 18, 2021; however she did not save the computerized reassessment, therefore there was no evidence a reassessment was completed until August 23, 2021 (or five days after the move). RN-D verified R1's medications were not administered until after a medical appointment on August 23, 2021. R1 had prescriber orders dated August 23, 2021, that included, but not limited to	01160		

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01160	Continued From page 27 Hydrochlorothiazide (anti-hypertensive) 25, milligrams (mg), Losartan (anti-hypertensive) 100 mg daily. On September 23, 2021, at 9:20 a.m., RN-B stated a medical evaluation was not suggested on August 18, 2021, nor were prescriber orders obtained until August 23, 2021. RN-B stated the family could have stayed with R1 and/or an outside agency could have been obtained to provide additional services in the apartment. The Change in Condition policy dated November 20, 2019, noted all residents were monitored for changes in condition. When a change occurs, appropriate health professionals, residents and/or responsible parties will be informed in a timely manner. Staff must immediately notify the nurse, consult the the resident's primary provider and notify the resident's responsible part when there is a significant change in the resident's physical, mental or psychosocial status. The facilities undated Disclosure of Special Services Memory Care, noted in cooperation with the family members, comprehensive interviews, cognitive and nursing assessments were conducted by professional staff before and upon admission. The resident's family should be an active participant in care plan development. "Our staff will update family with any changes in resident care."; in addition, family visits "are not restricted." A policy and procedure regarding transfers within the facility was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01160		

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01160	Continued From page 28 days	01160		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of one unlicensed personnel (ULP-D) with record reviewed. 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: Record review of ULP-D's employee record indicated ULP-D started providing home care services via a contracted supplemental staffing	01460		

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01460	Continued From page 29 agency on March 23, 2021. ULP-D lacked the required orientation to assisted living licensing requirements and regulations with the required content. On September 21, 2021, at 7:00 a.m., ULP-D was observed in the memory care unit assisting residents with personal care services. ULP-D stated she was current on the nursing assistant registry and had approximately a 30 minute orientation with a registered nurse (RN) when she initially came to the facility. On September 23, 2021, at 10:00 a.m., Registered Nurse (RN)-B and the administrator verified the lack of employee records for all contracted staff who provided services for the facility. RN-B and the administrator stated the supplemental nursing agencies guaranteed staff had all the necessary training and orientation. RN-B and the administrator were unable to verify ULP-D's orientation to the assisted living licensing requirements and regulations. The Orientation and Annual Training-AL (Assisted Living) policy dated March 29, 2019, noted all staff completed an orientation to the assisted living licensing requirements and regulations before providing assisted living services to clients. "Any staff who has received orientation from another home care agency must receive this training from Cassia upon hire." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		

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01620	Continued From page 30	01620		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident reassessment and monitoring was conducted as needed based on changes in the needs of the resident for one of one resident (R1) with record reviewed. 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	01620		

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01620	Continued From page 31	01620		

cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1's "Admission Assessment" dated August 16, 2021, noted R1 was independent with activities of daily living, including bathing, dressing, and toileting. According to the assessment, R1 could not locate her medications. The vulnerability assessment was not completed and blank. A SLUMS examination (screening tool for dementia developed by Saint Louis University geriatricians that identifies cognitive problems-a score below 20, indicative for dementia) indicated a score of 11 out of 30.

R1 was transferred to the memory care unit on August 18, 2021, however lacked documentation a reassessment was completed until August 23, 2021 (or five days after the move). This was verified with Registered Nurse (RN)-D on September 22, 2021, at 10:45 a.m. RN-D stated she completed the assessment on August 18, 2021, however she forgot to save the computerized assessment, and it was lost.

R1's assessment dated August 23, 2021, described R1 as independent with personal hygiene, including showers, with cues to complete hygiene and grooming tasks. R1's mobility assessment included a wheeled walker.

R1's SLUMS (screening tool for dementia developed by Saint Louis University geriatricians that identifies cognitive problems-a score below 20, indicative for dementia) exam dated August

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01620	Continued From page 32 23, 2021, noted R1 scored 9 out of 30. A MAARC (Minnesota Adult Abuse Reporting Center) report dated August 23, 2021 (same date of the assessment above), noted R1's "gait is very concerning for ambulation with severe leaning back and stumbling." Resident Notes dated August 23, 2021, "Her ambulation was poor so family did bring her walker in to use which she forgets to use in random places." Resident Notes, dated September 3, 2021, noted R1 fell and was found in her room on the floor without injury. On September 22, 2021, at 10:45 a.m., RN-D stated R1 was independent with showers, despite the documentation dated August 23, 2021, and the fall dated September 3, 2021. When asked how she knew if R1 showered since her admission, reported staff "peek" in when she was showering. RN-D verified a lack of documentation of any showers. When asked if R1's ability to shower independently was assessed and if R1 was safe to do so, RN-D verified it was not and indicated R1 did not want people in her room. The Change in Condition policy dated November 20, 2019, noted all residents were monitored for changes in condition. When a change occurs, appropriate health professionals, residents and/or responsible parties will be informed in a timely manner. Staff must immediately notify the nurse, consult the the resident's primary provider and notify the resident's responsible part when there is a significant change in the resident's physical, mental or psychosocial status.	01620		

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01620	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan was revised based on assessment and changes in services for one of one resident (R1) with record reviewed.	01640		

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01640	Continued From page 34 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's service plan dated August 20, 2021, lacked a revision to include medication management services. On September 22, 2021, at 10:45 a.m., registered nurse (RN)-D verified R1 received medication administration, and indicated she forgot to revise the service plan. RN-D indicated medication management services were provided since August 23, 2021. The Service Plan policy dated March 29, 2019, indicated whenever there were changes to the services provided, the service plan was to be revised/modified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must	01760		

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include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure each medication administered by the assisted living facility was documented in the record and when not administered as prescribed, documentation included the reason why and follow-up procedures that were provided to meet the resident's needs for two of two residents (R1 and R3) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1
R1's prescriber orders dated August 23, 2021, to include, but not limited to, Hydrochlorothiazide (anti-hypertensive) 25, milligrams (mg), Losartan

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(anti-hypertensive) 100 mg daily, fish oil (nutritional supplement) 1000 mg daily, and multivitamin daily.

R1's September 2021 medication administration record (MAR) lacked documentation the fish oil capsule and the multivitamin were administered until September 13, 2021. This was verified with Registered Nurse (RN)-D on September 22, 2021, at 10:45 a.m., RN-D stated R1 did not have the medications available and indicated she contacted the family to pick up the medications, although verified a lack of documentation of the request.

R3

R3's diagnosis was chronic pain.

R3's service plan dated May 7, 2021, indicated R3 received services which included medication management services.

R3's Individualized Medication Management Plan (MMP) dated August 28, 2021, also noted R3 received medication administration as prescribed. The MMP noted directions for administering, monitoring and documenting medication would be listed on the MAR.

R3's prescriber orders dated August 10, 2021, noted an order for dorzolamide 0.02% (glaucoma) one drop in affected eyes twice daily.

On September 21, 2021, at approximately 7:00 a.m., unlicensed personnel (ULP)-C was observed assisting with administration of R3's scheduled eye drops after visually reviewing the electronic September 2021 MAR.

R3's September 2021 MAR noted the dorzolamide prescribed eye drops were not

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01760	Continued From page 37 administered on September 8 at 8:00 p.m., September 9 at 8:00 a.m., and September 10 at 8:00 p.m. with notations of "med out of stock, nurse notified, not available, and still don't know where they are." R3's record lacked evidence of any follow-up procedures that were provided to meet the resident's needs. On September 23, 2021, RN-Director of Clinical Services confirmed R3's record lacked evidence of any follow-up procedures related to the prescribed eye drops not available for administration. The Medication Administration policy dated December 18, 2019, noted medications would be administered to residents as prescribed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication set-up included dates of medication set-up, name of medication, quantity of dose, times to be administered, route	01770		

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01770	Continued From page 38 of administration, and name of person completing medication set-up must be done at the time of set-up for one of one resident (R1) with record reviewed. 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: During the entrance conference on September 20, 2021, at 9:30 a.m., registered nurse (RN)-D indicated medications were usually in pharmacy issued bubble packs, but some residents had medications set-up weekly by the nurse. On September 21, 2021, at 7:00 a.m., R1's medications were observed in a seven-day dosage box in the medication cart on the memory care unit. R1's record lacked documentation of the set-up to include the name of medication, quantity of dose, times to be administered, and route of administration. On September 22, 2021, at 3:15 p.m., RN-D verified R1's record lacked documentation of the medication set-up with all the required content. The Medication Set Up and Documentation policy, dated August 7, 2019, noted medication set-up was documented in the resident's record.	01770		

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01770	Continued From page 39 "The nurse will document each medication set up on the electronic medication administration record (EMAR)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 40 evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required policies and procedures were provided to each resident and/or the resident's legal and designated representative at the time of move-in. 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 potential to affect a large portion or all of the residents). Findings include: The licensee lacked evidence the required policies and procedures related to the dementia care were provided to each resident and/or the resident's legal and designated representative. On September 23, 2021, at 11:00 a.m., the Regional Director of Assisted Living Services indicated the policies were available to the resident's and/or representatives, which were located in a notebook/binder, but the policies were not provided to each resident and/or representative at the time of move-in.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

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02110	Continued From page 41 The Dementia Disclosure policy dated August 1, 2021, noted the required policies were available, but lacked procedures how they were distributed to each resident and/or representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
03000 SS=D	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 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	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

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03000	Continued From page 42 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 observation, interview and record review, the licensee failed to ensure an allegation of suspected maltreatment was reported to Minnesota Adult Abuse Reporting Center (MARRC) timely for one of one resident (R1) with an injury of unknown origin reviewed. 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	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	4350 CHIPPEWA COURT MEDINA, MN 55340

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03000	Continued From page 43 situation has occurred only occasionally). The findings include: A initial MAARC reported dated August 23, 2021, at 5:37 p.m. noted on the morning of August 21, 2021, R1 was observed with eye discoloration (unknown origin). R1's assessment dated August 23, 2021, described R1 as independent with bathing, dressing and grooming with cues and/or set-up. A SLUMS (screening tool for dementia developed by Saint Louis University geriatricians that identifies cognitive problems-a score below 20, indicative for dementia) exam noted R1 scored 9 out of 30. On September 21, 2021, at 10:45 a.m., R1 was observed to have an area of dark blue discoloration below the right eye, smaller than one inch in length and approximately 1/2 inch width. When asked how the discoloration occurred, R1 reported it had something to do with a friend, but it was "over" and "done" and did not want to discuss it further. A MAARC report dated August 23, 2021, noted discoloration under R1's right eye that measured 1 cm (centimeter) x 2 cm red purple area with some yellowing outer brow. The report indicated the discoloration was initially observed on the morning of August 21, 2021. When staff questioned how it occurred, R1's story changed from an unwitnessed fall to someone hitting her. "After further questioning she said it was another resident then changed her story to 'last night.' " The facility's internal investigation lacked dates, times and names of individuals who were	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	09/23/2021

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03000	Continued From page 44	03000		

interviewed regarding the discoloration. The documentation consisted of a narrative summary dated August 23, 2021, with additional notes dated August 31, 2021, and September 7, 2021. The investigation was completed by registered nurse (RN)-D and the administrator.

On September 20, 2021, at 3:40 p.m., R1's family member (F)-M stated R1 moved into an "independent apartment" on August 16, 2021, and was transferred to the memory care unit on August 18, 2021. F-M stated R1 reported she was "punched" during an altercation with an individual around or during the time of the move. (During an interview with R1 on September 22, 2021, at 10:45 a.m. R1 reported she had no recollection of a move).

On September 22, 2021, at 10:45 a.m., RN-D stated when she came to work on Monday (August 23, 2021) she was informed of R1's "bruise." RN-D verified the incident was not reported to MAARC timely because staff thought it had been previously reported. RN-D stated as time progressed, the bruising and swelling around R1's eye increased. (However, there was no documentation of the progression-which was verified on the same date and time). RN-D stated R1 thought she (RN-D) hit her and caused the bruise. The investigation noted video footage was reviewed, which noted R1 did not have any bruising on Friday (August 20, 2021), and the bruising was observed on Saturday (August 21, 2021). RN-D verified she physically moved R1 to the memory care unit on August 18, 2021.

The Abuse Prohibition-AL-MN policy dated February 2019, noted employees were directed to immediately report suspected/alleged violations of maltreatment to the registered nurse. "Report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35700	A. BUILDING: _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OKALEE OF MEDINA	**4350 CHIPPEWA COURT MEDINA, MN 55340**

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03000	Continued From page 45 all alleged violations and substantiated incidents immediately to the state agency as required." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *09/22/21*
Time: 14:00:00
Report: 8087211262

Food and Beverage Establishment Inspection Report

Location:
Okalee
4350 Chippewa Court
Medina, MN55340
Aitkin County,

Establishment Info:
ID #: N001234
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/21

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

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.

NO VOMIT/FECAL MATTER CLEAN-UP KIT OR PROCEDURES IN PLACE IN KITCHEN. ESTABLISHMENT HAD EXTRA KITS IN STORAGE AND POLICY AND KIT WAS PUT IN PLACE BY OPERATOR. CORRECTED ON SITE.

Corrected on Site

Surface and Equipment Sanitizers

Wash Temperature Gauge: = -- at 171 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 186 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 171 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at -- Degrees Fahrenheit
Location: WALL DISPENSING UNIT
Violation Issued: No

Quaternary Ammonia: = 200 PPM at -- Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 5 Degrees Fahrenheit - Location: ICE CREAM COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 4 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: PUDDING
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: WHIPED CREAM
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 34 Degrees Fahrenheit - Location: MILK COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 32 Degrees Fahrenheit - Location: MILK COOLER
Violation Issued: No

Process/Item: Cold Holding: CREAMER
Temperature: 34 Degrees Fahrenheit - Location: MILK COOLER
Violation Issued: No

Process/Item: Hot Holding: SOUP
Temperature: 153 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: CUSTOMER SELF-SERVICE COOLER
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 36 Degrees Fahrenheit - Location: CUSTOMER SELF-SERVICE COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT TOMATO
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding: HB EGG
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: TUNA SALAD
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Holding: POTATO SALAD
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Thawing: MUFFIN MIX
Temperature: 26 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT MELON
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT LFY GRN
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: LIQUID EGG
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: -3 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION DONE WITH FOOD SERVICE DIRECTOR MICHELLE A. OTTO.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO 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 8087211262 of 09/22/21.

Certified Food Protection Manager: MICHELLE A. OTTO

Certification Number: FM 64407 Expires: 09/18/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
MICHELLE A. OTTO
FOOD SERVICE DIRECTOR

Signed: _____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us

Report #: 8087211262

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 North Robert Street
Saint Paul, MN

No. of RF/PHI Categories Out	1	Date	09/22/21
No. of Repeat RF/PHI Categories Out	0	Time In	14:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Okalee	4350 Chippewa Court	Medina, MN	55340	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
N001234		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item. Mark "X" in appropriate box for COS and/or R.

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 09/24/21

Inspector (Signature) Josh Kent