Electronically Delivered

March 3, 2023

Licensee
Eagan Pointe Senior Living LLC
4232 Black Hawk Road
Eagan, MN 55122

RE: Project Number(s) SL31786015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 2, 2023, 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.

LICENSING ORDERS
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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

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

The correction order documentation should include the following:

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

specific statute(s).

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31786	A. BUILDING: _____ B. WING _____	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGAN POINTE SENIOR LIVING LLC	4232 BLACK HAWK ROAD EAGAN, MN 55122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION****** ASSISTED LIVING 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: SL31786015-0 On January 30, 2023 through February 2, 2023, 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 one hundred fifty-two (152) residents, of whom, 108 received 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 with Dementia Care facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated February 1, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. 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: On January 31, 2023, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-F administer two different types of insulin in R5's abdomen with gloves on. Once completed, ULP-F put supplies away then handled the work phone where they obtain resident care plans. ULP-F then proceeded to collect the trash out of the bin and tied it up. With same gloves on, ULP-F then washed R5's dishes then removed gloves.	0 510		

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0 510	Continued From page 3 On January 31, 2023 at 8:35 a.m., surveyor asked ULP-F when they were trained to remove gloves, ULP-F stated gloves needed to be removed after each task. ULP's Nursing Staff Orientation Checklist 5.12 dated January 11, 2023, indicated ULP was signed off by a registered nurse (RN) showing competency on the following: -infection control, -blood borne pathogens, and -hand washing, On January 31, 2023, at 9:26 a.m., regional director of nursing (RDON)-J and registered nurse (RN)-B both verified it was expected all staff remove gloves right after insulin administration. The licensee's 8.07 Gloves policy dated August 1, 2021, indicated staff will remove gloves and dispose used gloves in proper receptacle and rewash hands. The licensee's 8.09 Hand washing policy dated August 1, 2021, indicated proper hand washing techniques should be performed after touching garbage. The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance in Health Care Settings last reviewed January 30, 2020, directed health care workers to use an alcohol-based hand rub or wash with soap and water immediately before touching a patient (resident), before moving from work on a soiled body site to a clean body site on the same patient and immediately after glove removal. No further information was provided.	0 510		

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0 510	Continued From page 4 TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
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 maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents 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 February 2, 2023, approximately from 10:30 a.m. to 2:00 p.m. survey staff toured the facility with the liscensed assisted living director (LALD)	0 800		

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0 800	Continued From page 5 -A and the Regional Vice President of Operations (RVPO)-C. The RVPO-C joined the tour at 11:00 a.m. During the tour, survey staff observed the following: 1. The exterior walkway of a marked exit door in the main dining room had snow cover that had not been maintained in the means of egress from a building exit door. The LALD-A verified the finding. 2. The two trash rooms in the basement level had fire-rated doors that failed to close and positively latch to maintain the fire rating of the rooms. In addition, one trash door had a missing door handle and damaged hardware on the inside side. The RVPO-C confirmed the findings. 3. In room 130, the shower fixture was used as storage space stacked with boxes. Survey staff explain the shower drain/trap if not utilized by the resident, needs to be maintained to prevent sewer gas from which would allow sewer gas to enter the building environment creating unsafe and health risks to residents and employees. The RVPO-C confirmed the finding. On February 2, 2023, at approximately 3:00 p.m., during the exit interview, the LALD-A and the RVPO-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not	0 970		

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0 970	Continued From page 6 include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for resident health, safety, or personal property. This had the potential to affect all residents. This practice resulted in a level one 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: The licensee's Assisted Living Contract included a section for Indemnification that read, "Resident will indemnify and hold harmless provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act or omission of resident..." On January 30, 2023, at 12:35 p.m. Regional Vice President of Operations (RVPO)-C	0 970		

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0 970	Continued From page 7 confirmed the licensee's assisted living contract included the above content, and stated the same contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060		

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01060	Continued From page 8 (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 January 30, 2023, at approximately 10:20	01060		

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01060	Continued From page 9 a.m, licensed assisted living director (LALD)-A identified R1 was sent to the hospital on January 18, 2023, and was currently at a transitional care unit. R1's record lacked evidence of a written notice, when R1 was relocated and had not returned to the facility within four days; the record lacked evidence the required written notice was provided to the resident, legal representative, or to the OOLTC as soon as practicable and included the following minimum content: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On January 30, 2023, at 11:36 a.m., LALD-A stated they were unaware of the requirement and stated this had not be provided to any resident with an emergency relocation. LALD-A stated they would only notify the family informally whenever a resident went into the hospital. The licensee's 1.22 Emergency Relocation policy dated August 1, 2022, indicated the licensee would provide a notice that contained the required statutory content to each resident when an emergency relocation occurred.	01060		

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01060	Continued From page 10 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or 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 observation, interview and record review, the licensee failed to ensure documentation of direct supervision of unlicensed personnel (ULP) for one of one employee	01440		

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01440	Continued From page 11 (ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-I was hired on April 5, 2022, to provide direct care under the assisted living with dementia care license. On January 31, 2023, at approximately 9:00 a.m., ULP-I was observed to provide medication administration to a resident of the licensee. On February 1, 2023, at approximately 11:45 a.m., registered nurse (RN)-B confirmed ULP-I's record lacked evidence the RN supervised ULP-I performing the delegated task. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began working for the licensee, first performs the delegated tasks, and thereafter as needed, based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		

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01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment to include all areas required on the uniform assessment tool for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01620		

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	31786	A. BUILDING: _____ B. WING _____	02/02/2023

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01620	Continued From page 13 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 January 30, 2023, at approximately 2:00 p.m., unlicensed personnel (ULP)-D was observed to provide medication assistance to R3. R3's Service Plan dated October 17, 2022, indicated R3 received services to include medication assistance, bathing, toileting assistance, and housekeeping. On January 31, 2023, at approximately 9:00 a.m., ULP-I was observed to provide medication assistance to R4. R4's Service Plan dated October 13, 2022, indicated R4 received services to include include medication assistance, bathing, and housekeeping.. R3's and R4's 90-day reassessments dated December 19, 2022, and November 28, 2022, respectively, lacked areas required on the uniform assessment tool including: -advanced health care directive, -physical health status, -cognition, -list of treatments, -risk indicators, and -who had decision-making authority for the resident On January 31, 2023, at 12:32 p.m., registered nurse (RN)-B and Regional Director of Nursing	01620		

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01620	Continued From page 14 (RDON)-J confirmed the licensee's nursing assessments lacked required information from the uniform assessment tool and stated they were unaware of the requirement. The licensee's Uniform Assessment Tool policy dated August 1, 2021, indicated a registered nurse would utilize a uniform assessment tool that addressed all required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or	01700		

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01700	Continued From page 15 designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized assessment to determine what medication management services would be provided, and how the services would be provided for two of two residents (R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 30, 2023, at approximately 10:20 a.m., RN-B confirmed the licensee provided medication management services to the licensee's residents. R5 On January 31, 2023, at 8:25 a.m., surveyor observed unlicensed personnel (ULP)-F administer both Lantus (long acting insulin) and NovoLog (fast acting insulin) to R5 in the abdomen.	01700		

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01700	Continued From page 16 R5 had diagnoses of diabetes type II. R5's Individualized Services Amendment signed October 19, 2022, indicated R5 received medication assistance. R5's record lacked evidence the RN had conducted a medication assessment and developed a management plan to include: -an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. R6 On January 31, 2023, at 9:40 a.m., surveyor observed ULP-G apply ABH Gel (hospice provided mediation for agitation) to R6's left inner wrist and apply nebulizer treatment while R6 was sitting up in bed. R6 had diagnoses of unspecified dementia with behavioral disturbance, and chronic kidney disease, stage 3. R6's Individualized Services Amendment signed November 18, 2022, indicated R6 received medication assistance. R6's medical record lacked evidence the RN had conducted a medication assessment and developed a management plan to include: -an identification and review of all medications the resident was known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. On February 1, 2023, at 9:40 a.m., registered	01700		

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01700	Continued From page 17 nurse (RN)-B stated staff had access to drugs.com on their work phones to look up side effects and confirmed residents lacked assessments to review and identify all medications they were known to be taking. RN-B stated they were unaware of the requirement and it was not done for all residents receiving medication assistance. The licensee's 7.01 Medication Management-Assessment, Monitoring and Reassessment policy dated August 1, 2021, indicated the assessment must include an identification and review of all medications the resident was known to be taking. Additionally, the policy indicated the review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01760 SS=F	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 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	01760		

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01760	Continued From page 18 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 medication administration was documented accurately for two of two residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 On January 30, 2023, at approximately 2:00 p.m., unlicensed personnel (ULP)-D was observed to provide medication assistance to R3. R3's Individualized Services Amendment, signed October 17, 2022, indicated R3 received Medication Assist. R3's Medication Administration Record (MAR) for January 2023, lacked the medication name, dosage, and method and route of administration of all R3's medications. R4 On January 31, 2023, at approximately 9:00 a.m., ULP-I was observed to provide medication assistance to R4. R4's Individualized Services Amendment signed	01760		

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01760	Continued From page 19 October 13, 2022, indicated R4 received Medication Assist. R4's Medication Administration Record (MAR) for January 2023, lacked the medication name, dosage, and method and route of administration of all R4's medications. On January 31, 2023, at approximately 9:26 a.m., registered nurse (RN)-B and Regional Director of Nursing (RDON)-J confirmed the licensee's MAR lacked the required documentation related to mediation administration and stated they would need to print a new form for documenting medication assistance. The licensee's Medication Management-Administration and Setup policy dated August 1, 2021, directed assistance with medication be documented on the MAR by entering the ULP's initials under the date and opposite the medication and dose given. For assistance with medications from the dosage box system, the ULP should use the MAR for documenting medications given from a dosage box and should refer to the medication profile. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained including the opened date for time sensitive medication storage, for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5 had diagnoses of diabetes type II, traumatic brain injury anxiety and tobacco use disorder. R5's Individualized Services Amendment signed October 19, 2022, indicated R5 received medication assistance. On January 31, 2023, at 8:25 a.m. while unlicensed personnel (ULP)-F was observed preparing R5's insulin, both the Lantus and Novolog FlexPens lacked identification or evidence of when the insulins were opened. ULP-F stated they were not the person who opened the insulins and was unsure how long they had been opened. R5's signed Physician Order Sheet directed: -insulin glargine (Lantus FlexPen)- inject 44 units of Lantus subcutaneously daily in the morning. - insulin aspart (Novolog FlexPen) - inject 7 units of Novolog subcutaneously three times a day at	01890		

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01890	Continued From page 21 meal times. On January 31, 2023, at 9:26 a.m., registered nurse (RN)-B stated R5's Novolog and Lantus insulin FlexPens should have been marked with an opened date and further stated ULP were trained to do so. The licensee's 7.10 Medications Storage policy dated August 1, 2021, indicated the licensee would store medications per manufacturer's directions. Lantus FlexPen manufacturer instructions dated as revised January 2021, directed the medication should be discarded 28 days after opened. Novolog FlexPen manufacturer instructions dated as revised March 2021, directed the medication should be discarded 28 days after opened. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01930 SS=D	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must	01930		

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01930	Continued From page 22 address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to implement the written treatment or therapy management policies and procedures, for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 failed to implement treatment or therapy management policies and procedures by notifying a registered nurse (RN) when a blood glucose reading was above 250. R5 had diagnoses of diabetes type II. R5's Individualized Services Amendment signed October 19, 2022, indicated R5 received treatment assistance. On January 31, 2023, at 8:25 a.m., during a treatment observation, unlicensed personnel	01930		

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01930	Continued From page 23 (ULP)-F assisted R5 with blood glucose monitoring. The blood glucose result was 273. On January 31, 2023, at 8:29 a.m., surveyor asked ULP-F what the blood glucose parameters were, and ULP-F stated they believed it was between "60-70 and 250" and was not able to locate the parameter to confirm. ULP-F proceeded to administer insulin without contacting the nurse. R5's Service Checkoff List dated January 2023, directed ULP to record the blood sugar and notify nurse if blood glucose was less than 70 or above 250. On January 31, 2023, at 11:01 a.m., registered nurse (RN)-B verified ULP-F did not notify of R5's blood glucose reading of 273. RN-B stated ULP-F should have notified the nurse as it was their policy. The licensee's 7.29 Blood Sugar Testing-Single Equipment Use policy dated August 1, 2021, indicated the licensee would document the results of the reading and notify the RN of any unusual results. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and	02110		

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02110	Continued From page 24 procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures, for two of two residents (R1, R4).	02110		

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02110	Continued From page 25 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 and R4's records lacked evidence the resident or residents' representative were provided the additional required policies and procedures for assisted living facilities with dementia care. On January 30, 2023, at 11:36 a.m., licensed assisted living director (LALD)-A stated the dementia care policies and procedures were provided to residents or resident's representative if they were in memory care, but LALD-A was unaware it was required for all residents admitted to licensee. LALD-A stated they did provide the disclosure to independent and assisted living residents, but not the policies and procedures. The licensee's 3.00 Assisted Living with Dementia Care Additional Required Policies policy dated August 1, 2022, indicated the licensee would provide residents and resident's legal and designated representatives at the time of move-in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/01/23*
Time: 10:30:00
Report: 1005231024

Food and Beverage Establishment Inspection Report

Location:
Eagan Pointe Senior Living Llc
4232 Black Hawk Road
Eagan, MN55122
Dakota County, 19

Establishment Info:
ID #: 0038718
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6517242312
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3 ** Priority 1 **

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

IN THE 3RD FLOOR MEMORY CARE KITCHENETTE, THE SPRAY BOTTLE HAD 0 PPM QUATERNARY AMMONIUM, BECAUSE THE DISPENSER WAS COMING OUT AT LESS THAN 50 PPM. FILL BOTTLES FROM A DIFFERENT DISPENSER UNTIL REPAIRED.

Comply By: 02/01/23

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 SANITIZER DISPENSER IN THE 3RD FLOOR MEMORY CARE KITCHENETTE WAS DISPENSING INCONSISTENTLY, AND AT LESS THAN 50 PPM QUATERNARY AMMONIUM. FILL SPRAY BOTTLES FROM A DIFFERENT DISPENSER, UNTIL 3RD FLOOR DISPENSER IS PROVIDING 200-400 PPM QUAT.

Comply By: 02/08/23

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

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

Quaternary Ammonia: = 0PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE, 3RD FLOOR
Violation Issued: Yes

Quaternary Ammonia: = 0PPM at Degrees Fahrenheit
Location: DISPENSER, 3RD FLOOR
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/HARD BOILED EGG
Temperature: 38 Degrees Fahrenheit - Location: MINI FRIDGE, SERVER AREA
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: DELFIELD UNDER COUNTER COOLER, SERVER AREA
Violation Issued: No

Process/Item: Cold Hold/HARD BOILED EGG
Temperature: 35 Degrees Fahrenheit - Location: SUPERIOR 2-DOOR COOLER
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 32 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 37 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Hot Hold/VEGGIE SOUP
Temperature: 180 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

Process/Item: Hot Hold/LASAGNA
Temperature: 175 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Hot Hold/FISH
Temperature: 165 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Cold Hold/TUNA
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/WATERMELON
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/PASTA
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

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

Process/Item: Cooling/MUSHROOMS
Temperature: 76 Degrees Fahrenheit - Location: WALK-IN COOLER, 30 MINUTES
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 35 Degrees Fahrenheit - Location: 1ST FLOOR KITCHENETTE COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 36 Degrees Fahrenheit - Location: 2ND FLOOR KITCHENETTE COOLER
Violation Issued: No

Process/Item: Cold Hold/HARD BOILED EGG
Temperature: 38 Degrees Fahrenheit - Location: 3RD FLOOR KITCHENETTE COOLER
Violation Issued: No

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

INSPECTION COMPLETED WITH KITCHEN MANAGER AND FACILITY DIRECTOR. REPORT WAS REVIEWED WITH HRD NURSE EVALUATOR ROBYN WOOLLEY.

DISCUSSED EMPLOYEE ILLNESS, COOLING, NON-CONTINUOUS COOKING, AND THERMOMETER CALIBRATION.

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1005231024 of 02/01/23.

Certified Food Protection Manager: MATTHEW A. LUCEY

Certification Number: FM70407 Expires: 10/26/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

MATT LUCEY
KITCHEN MANAGER

Signed: _____

Jessica Davis
Public Health Sanitarian III
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