Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 1, 2025

Licensee
Encore at Mahtomedi
720 Mahtomedi Avenue
Mahtomedi, MN 55115

RE: Project Number(s) SL28353016

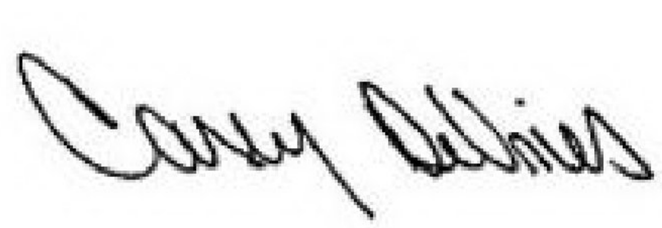
Dear Licensee:

On April 7, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 16, 2025. This follow-up survey verified that the facility is in substantial compliance..

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Electronically Delivered

February 25, 2025

Licensee
Encore At Mahtomedi
720 Mahtomedi Avenue
Mahtomedi, MN 55115

RE: Project Number(s) SL28353016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 16, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

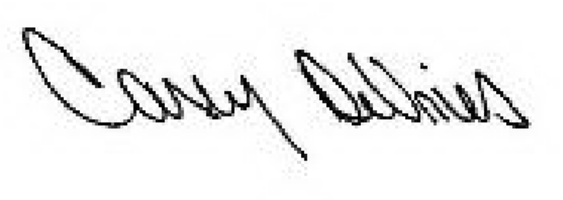
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28353	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28353016-0 On January 13, 2025, through January 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 45 resident(s); 45 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on January 15, 2025, issued for SL28353016-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 14, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to gloving and hand hygiene for one of one employee (unlicensed personnel (ULP)-E). 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).	0 510		

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0 510	Continued From page 4 The findings include: ULP-E began employment with the licensee on November 20, 2023, to provide assisted living services. On January 14, 2025, from 8:14 a.m., to 8:51 a.m., during continuous observation, the surveyor observed ULP-E administer medications to residents residing within the facility. At 8:14 a.m., the surveyor observed ULP-E complete hand hygiene at a sink and put on clean gloves. ULP-E then prepared medications for R7. After administering medications, ULP-E removed their gloves, and put on a new set of gloves without completing hand hygiene. ULP-E then prepared medications for R8. After ULP-E administered R8's medications, ULP-E returned to the medication cart to document administration. The surveyor observed ULP-E remove their gloves, and without performing hand hygiene, ULP-E began searching the unit for additional gloves. ULP-E then returned to the sink, completed hand hygiene and put on clean gloves. ULP-E completed documentation at the medication cart and removed their gloves but did not complete hand hygiene. At 8:44 a.m., the surveyor observed ULP-E enter R7's room, put on clean gloves without completing hand hygiene and administer creams to R7. On January 14, 2025, at 8:50 a.m., ULP-E stated they were trained to complete hand hygiene before, after, and in between all glove changes. On January 14, 2025, at 2:04 p.m., clinical nurse supervisor (CNS)-B stated staff completed training on hand hygiene and were expected to complete hand hygiene before, after, and in	0 510		

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0 510	Continued From page 5 between glove changes. CNS-B stated staff may use hand sanitizer to complete hand hygiene between glove changes but should still wash hands at sink around every third use of hand sanitizer. The licensee's 2.46 Infection Control policy date December 2021, indicated staff must perform hand hygiene at the following times: Before: - Having contact with residents - Putting on gloves - Caring for an invasive device, such as a catheter - Handling food - Administering medication After: - Having contact with resident's skin - Having contact with bodily fluids (even when gloves are worn) - Having contact with resident's items such as dressings, dirty laundry, dishes or trash - Taking off gloves - Moving from parts of the resident's body that could be contaminated to clean parts of the resident's body - Using the restroom - Coughing or Sneezing - Smoking The CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, subsection 5a. Hand Hygiene References and resources indicated the following: 1. Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations. 2. Use an alcohol-based hand rub or wash with soap and water for the following clinical	0 510		

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0 510	Continued From page 6 indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 660		

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0 660	Continued From page 7 by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated December 11, 2024, indicated the facility was a low risk. ULP-E was hired November 20, 2023, to provide assisted living services. ULP-E's employee record lacked documentation indicating the completion of a two-step TST or other evidence of TB screening such as a blood test. On January 16, 2025, at 9:25 a.m., clinical nurse supervisor (CNS)-B stated ULP-E's employee record was incomplete and they were working on developing a new system for tracking employee TB screenings.	0 660		

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0 660	Continued From page 8 The licensee's 2.02 Tuberculosis (TB) Screening policy dated February 2022 indicated new staff will have an IGRA (interferon gamma release assay) blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs (health care workers). No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. 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	0 680		

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0 680	Continued From page 9 elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 680		

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0 680	Continued From page 10 The findings include: The licensee's written emergency disaster preparedness plan lacked evidence of the following required content: - annual review of the EPP; - the licensee's EPP was dated March 2013; - quarterly review of missing resident policy; - a written risk assessment utilizing an all-hazards approach; - categorization of probable risks by likelihood of occurrence; - written strategies addressing facility and community-based risks; - missing resident plan; - policies and procedures to identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - policies and procedures for cooperation and collaboration with local, tribal, regional, state and federal EP to maintain integrated response; - development and annual review of EP policies based on the EP, risk assessment and communication plan; - policies and procedures for subsistence needs for staff and residents; - policies and procedures to address needs for staff and residents whether evacuated or sheltered in place; - policies and procedures for tracking of staff and residents; - polices and procedures addressing the use of volunteers, including the process/role for integration; - policies and procedures addressing the development of arrangements with other facilities/providers to receive residents in the event of limitation/cessations of operation to maintain to continuity of services to residents;	0 680		

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	28353	A. BUILDING: _____ B. WING _____	01/16/2025

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0 680	Continued From page 11 - roles under wavier declared by secretary; - policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver; - development of communication plan; - names and contact information of staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - emergency officials contact information; - policies and procedures including primary and alternate means of communicating with facility staff, federal, state, tribal, regional, and local emergency management agencies; - policies and procedures for methods for sharing information and medical documentation for residents under the facility's care; - policies and procedures for sharing information on occupancy needs; - emergency prep testing to include a disaster drill; - emergency prep training program; and - emergency prep testing requirements. The licensee's 10.01 MN Disaster Planning and Emergency Preparedness policy dated June 2021, indicated the licensee will have in place a general emergency plan, that is in alignment with community's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss,	0 700		

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0 700	Continued From page 12 tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. This had the potential to affect all residents residing within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On January 14, 2025, from 8:34 a.m., to 8:40 a.m., the surveyor observed ULP-E left their computer screen open and unsecured while logged into the licensee's electronic medication administration record (EMAR). On January 14, 2025, at 8:51 a.m., ULP-E stated they were trained to secure medication carts and screens between medication administrations. ULP-E stated they had forgotten to lock screen due to it being a hectic morning. On January 14, 2025, at 2:12 p.m., clinical nurse	0 700		

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0 700	Continued From page 13 supervisor (CNS)-B stated the licensee was currently working on providing training to staff to ensure that computer monitors were secured in between medication passes. CNS-B stated it had been an ongoing issue with staff. The licensee's 2.51 HIPPA Privacy Authorization policy dated October 2016 indicated the licensee was responsible for protecting resident's health care information and release it to only individuals that they have chosen to share their protected medical information with. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	0 780		

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0 780	Continued From page 14 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide working emergency lighting, emergency power to exit signs, and access to the public was from the first-floor patio. This deficient condition had the ability to affect all staff and 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: On January 14, 2025, from 9:00 a.m. to 10:30 a.m., the surveyor toured the facility with maintenance (M)-G. The following was observed. Throughout the facility there were multiple emergency and exit lights that would not stay lit when tested. In the event of power loss, emergency and exit lights shall operate on battery power and remain illuminated for 30 minutes. M-G stated that he would replace all the batteries in all the	0 780		

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0 780	Continued From page 15 emergency and exit lights in the facility. The patio door on the first floor has an exit sign above it. The gate from the patio is locked from the outside and is not operable for the egress side. Egress shall be openable from the egress side. The gate on the patio was made from the same material as the rest of the fence and was not easily distinguishable as the gate. Where a gate is constructed of similar material to the fence the gate shall be identified with an approved exit sigh. The signed exit doors on first and third floors were locked with electromagnetic locks. The current configuration of the electromagnetic locks is not compliant as it does not provide a way to unlock the doors from an approved location. M-G, and licensed assisted living director (LALD)-A both confirmed that there was no way to unlock the electromagnetic locks from an approved location. The egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. The fire alarm report that was provide by M-G had two different and conflicting dates on it. The front page had 2022 noted as the year, and the back page had 2024 noted as the year. M-G, and LALD-A both stated that the annual service of the fire alarm was current. LALD-A stated that they had contacted the fire alarm contractor and	0 780		

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0 780	Continued From page 16 requested a new annual service report that did not have conflicting dates. The licensee failed to provide documentation that annual service was conducted on the sprinkler system. Both M-G and LALD-A stated that the testing was current. No report was provided. The service tag on the sprinkler riser indicated 9/18/2023 as the most recent service date. Water-based automatic fire extinguishing systems shall be inspected and tested annually. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 790		

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0 790	Continued From page 17 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: On January 14, 2025, from 9:00 a.m. to 10:30 a.m., the surveyor toured the facility with maintenance (M)-G. The following was observed. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. On January 14, 2025, at 10:30 a.m., the surveyor explained to M-G that the portable fire extinguishers must be provided with monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. M-G stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 18 (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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had	0 810		

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0 810	Continued From page 19 the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 14, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Emergency", dated June 2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar	0 810		

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0 810	Continued From page 20 emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On January 14, 2025, at 11:45 a.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee lacked documentation that employees were provided training on the facilities FSEP upon hire and at least twice per year. On January 14, 2025, at 11:45 a.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee lacked documentation that evacuation drills were conducted twice per year, per shift with at least one evacuation drill every other month. The licensee's fire drill policy stated that fire drills were to be conducted once per month.	0 810		

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0 810	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by:	0 900		

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0 900	Continued From page 22 Based on interview and record review, the licensee failed to develop and execute a written contract with the required content upon implementation of Assisted Living Licensure for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R2 was admitted to the licensee on June 16, 2020, and began receiving assisted living service on August 1, 2021. R2's record contained a resident agreement that was signed on June 17, 2020, under the licensee's prior comprehensive home care licensure. R2's record lacked evidence R2 executed a contract prior to being provided assisted living services. On January 16, 2025, at 9:50 a.m., regional director (RD)-H stated there were no additional contracts on file for R2, and they would be completing a full audit of the facility to ensure all residents had a contract that was up to date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		

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01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health	01370		

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01370	Continued From page 24 technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed in all required skill areas, prior to providing services, for two of two unlicensed personnel ((ULP)-D, ULP-E). 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: ULP-D began employment with the licensee on December 9, 2024, to provide assisted living services. ULP-E began employment with the licensee on November 20, 2023, to provide assisted living services. ULP-D and ULP-E's employee record lacked the following competency evaluation: - understanding appropriate boundaries between staff and residents and the resident's family. On January 16, 2025, regional director (RD)-H stated the licensee had training developed for professional boundaries, but had not implemented it into their initial training plans.	01370		

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01370	Continued From page 25 RD-H stated the training was offered in the licensee's annual training. The licensee's 5.47 Orientation of Staff and Supervisors & Content MN indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01440 SS=F	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	01440		

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01440	Continued From page 26 requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two unlicensed personnel ((ULP)-D, ULP-E). 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: ULP-D began employment with the licensee on December 9, 2024, to provide assisted living services. On January 14, 2025, from 7:13 a.m., to 7:42 a.m., the surveyor observed ULP-D administer medications to residents residing within the facility. ULP-E began employment with the licensee on November 20, 2023, to provide assisted living services. On January 14, 2025, from 7:52 a.m., to 8:51 a.m., the surveyor observed ULP-D administer medications to residents residing within the facility.	01440		

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01440	Continued From page 27 ULP-D, and ULP-E's employee record lacked record of 30-day supervision. On January 16, 2025, at 10:04 a.m., clinical nurse supervisor (CNS)-B stated they had not been completing 30-day supervisions with staff. CNS-B stated the licensee had a form for 30-day evaluation, but the form had not been utilized by the licensee, as they were not aware of its existence prior to the start of survey. The licensee's 5.48 Competency Training Evaluations MN dated June 1, 2021, indicated all staff delegated to perform home care tasks must have a supervisory visit completed within 30 days for starting a delegated service. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control	01500		

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01500	Continued From page 28 standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01500		

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01500	Continued From page 29 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment in the required annual training topics for two of two employees (clinical nurse supervisor (CNS)-B, and unlicensed personnel (ULP)-E). 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: CNS-B CNS-B began employment with the licensee on November 13, 2023, to provide clinical oversight and supervision of unlicensed personnel. ULP-E ULP-E began employment with the licensee on November 20, 2023, to provide assisted living services. On January 14, 2025, from 7:52 a.m., to 8:51 a.m., the surveyor observed ULP-D administer medications to residents residing within the facility. CNS-B and ULP-E's employee record lacked	01500		

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01500	Continued From page 30 eight hours of annual training in the following topics: - review of provider's policies and procedures. On January 16, 2025, at 9:37 a.m., regional director (RD)-H stated the licensee did not currently have an annual training for the review of the providers policies and procedures. The licensee's 5.50 Annual Required Staff Training MN policy dated February 2022, indicated the following training elements must be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct	01500		

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01500	Continued From page 31 support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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 interview and record review, the licensee failed to ensure the registered nurse	01620		

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01620	Continued From page 32 (RN) completed ongoing resident reassessments not exceed 90 days for two of three residents (R2, 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 potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted to the licensee on June 17, 2020, and began receiving assisted living services August 1, 2021. R2's unsigned Service Plan dated January 14, 2025, indicated R2 received services including medication management, full assistance with dressing, full assistance with bathing, two-person assistant with bowel and bladder, weekly vitals, housekeeping services, and laundry services. R2's record included an assessment dated July 21, 2021, and a 90-day assessment dated April 2, 2024, which indicated 986 days had lapsed between assessment dates, and 260 days had lapsed since R2's most recent assessment. No other assessments were on file for R2. R6 R6 was admitted to the licensee February 21, 2022, to receive assisted living services. R6's unsigned Service Plan dated January 14,	01620		

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01620	Continued From page 33 2024, indicated R6 received services including medications management, standby assist with oral cares, full assistance with dressing, physical assist with grooming, full assistance with bathing, behavior management, weekly vitals, assistance with bowel and bladder, assistance with oxygen therapy, assistance with mobility devices, assistance and coordination with hospice services, assistance with activities, housekeeping services, and laundry services. R6's record included a change of condition assessment dated March 12, 2024, and an assessment titled initial assessment dated January 13, 2025, indicating 307 days had lapsed since the last assessment. No other assessments were on file for R6. On January 15, 2025, clinical nurse supervisor (CNS)-B stated they had fallen behind on assessments due to there being direction to stop using the licensee's previous computerized charting system while the licensee transition to a new charting system. The licensee's 2.01 MN Assessments, Reviews & Monitoring policy dated June 2021 indicated 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01640	Continued From page 34	01640		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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 observation, interview, and record review, the licensee failed to ensure current service plans included a signature or other authentication by the resident to document agreement on the services to be provided for three of three residents (R2, R6, R7). 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	01640		

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01640	Continued From page 35 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: R2 R2 was admitted to the licensee on June 16, 2020, and began receiving assisted living service on August 1, 2021. R2's diagnoses included adjustment disorder, alcohol dependence, anxiety disorder, bipolar disorder, dementia, major depressive disorder, moderate multiple sclerosis, osteoporosis, personality disorder, and essential hypertension. R2's unsigned service plan, dated January 14, 2025, included full assistance with dressing, full assistance with bathing, two-person assist with toileting, weekly vitals, daily housekeeping services, and assistance with laundry. R6 R6 was admitted to the licensee on February 21, 2022, to receive assisted living services. R6's diagnoses included sepsis, hypomagnesemia, dementia, major depressive disorder, insomnia, Alzheimer's disease, neuro cognitive disorder, chronic systolic heart failure, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, benign essential microscopic hematuria, functional urinary incontinence, history of falling, and presence of cardiac pacemaker. R6's unsigned service plan, dated January 14,	01640		

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01640	Continued From page 36 2025, included standby assistance with oral cares, full assistance with dressing, physical assistance with grooming, full assistance with bathing, weekly vitals, assistance with bowel and bladder, medications administration, medications management, oxygen therapy, assistance with wheelchair use, coordination with hospice services, life enrichment, assistance with communication, housekeeping, and laundry assistance. R7 R7 was admitted to the licensee September 21, 2021, to receive assisted living services. R7's diagnoses included vitamin D deficiency, hyperlipidemia, Parkinson's disease, mild cognitive impairment of uncertain or unknown etiology, new daily persistent headache, essential hypertension, and gastroesophageal reflux disease without esophagitis. R7's unsigned Service Plan dated January 14, 2024, indicated R7 received assistance with medication management, full assistance with dressing, standby assist with grooming, full assistance with bathing, assistance with bowel and bladder, weekly vitals, assistance with mobility devices, assistance with glasses, housekeeping and laundry services. On January 16, 2025, at 10:21 a.m., clinical nurse supervisor (CNS)-B stated the licensee may have had a record of signed service plans on their previous computer system, but they were unable to obtain the records during the survey process. The licensee's 2.08 MN Service Plan Policy, dated July 2021, indicated the service plan and any revisions shall include a signature or other	01640		

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01640	Continued From page 37 authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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) completed face-to-face medication management re-assessments at least annually for one of three residents (R7) 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).	01710		

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01710	Continued From page 38 The findings include: R7 was admitted to the licensee September 21, 2021, to receive assisted living services. R7's diagnoses included vitamin D deficiency, hyperlipidemia, Parkinson's disease, mild cognitive impairment of uncertain or unknown etiology, new daily persistent headache, essential hypertension, and gastroesophageal reflux disease without esophagitis. R7's unsigned Service Plan dated January 14, 2024, indicated R7 received assistance with medication management, full assistance with dressing, standby assist with grooming, full assistance with bathing, assistance with bowel and bladder, weekly vitals, assistance with mobility devices, assistance with glasses, housekeeping and laundry services. On January 14, 2025, at 8:14 a.m., the surveyor observed unlicensed personnel (ULP)-E administer oral and topical medications to R7. R7's record contained a document titled Medication/ Treatment/ Therapy Management Plan Results dated April 18, 2023, which was utilized by the licensee as a medication management plan. R7's medical record lacked documentation indicating an annual medication management assessment was completed thereafter. On January 16, 2025, at 10:31 a.m., clinical nurse supervisor (CNS)-B stated they were aware that medication management plans needed to complete on an annual basis and was aware that they had not been completed. CNS-B stated this was an issue that had recently been addressed	01710		

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ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

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01710	Continued From page 39 and implemented in the licensee's new documentation system. The licensee's 2.82 MN Medication Management Individualized Plan failed to address the annual reassessment of medication management plans. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01770 SS=F	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 setup included all the required content for two of two residents (R9, R10). 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:	01770		

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01770	Continued From page 40 During the entrance conference on January 13, 2025, at 1:58 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services which included medication setup for their residents. On January 16, 2025, at 11:19 a.m., during an audit of the licensee's level two medication cart, the surveyor observed pill organizers containing medications setup for administration belonging to R9 and R10. R9 R9 was admitted to the licensee on October 14, 2024, to receive assisted living services. R9's record lacked a signed service plan indicating they received medication setup. R10 R10 was admitted to the licensee on May 11, 2023, to receive assisted living services. R10's record lacked a signed service plan indicating they received medication setup. On January 16, 2025, at 11:07 a.m., the surveyor asked about the documentation completed when performing medication set up. The surveyor explained to CNS-B that the documentation would need to include documentation of the dates of medication setup, names of medications, quantity of doses, times to be administered, route of administrations, and name of person completing medication setup. CNS-B stated the licensee had a form they used to document medication setup for all residents recieving medication setup services, but the form did not capture all the required content. Although	01770		

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01770	Continued From page 41 requested, the licensee did not provide documentation of their current medicaiton set up practice during the survey process. The licensees 2.39 Medication Management - Dosage Box Setup policy dated July the licensee would document medication set up with the following information: - Dates of medication setup; - Medication names; - Quantity of dose; - Times to be administered; - Route of administration; - Name of the person completing medication setup; - Visual description of medication; - Drug classification and special precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all	01880		

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01880	Continued From page 42 residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On January 14, 2025, at 7:52 a.m., the surveyor observed an unlocked medication cart, which was not under direct observation of staff in the licensee's first floor secured unit. On January 14, 2025, at 7:56 a.m., unlicensed personnel (ULP)-E stated they had unintentionally left the medication cart unsecured in the licensee first floor secured unit due to having to emergently step away to provide assistance to another staff member on the unit. On January 14, 2025, at 1:10 p.m., the surveyor observed the second-floor medication cart unlocked and not under direct observation of staff. On January 14, 2025, clinical nurse supervisor (CNS)-B stated it was the expectation of the licensee that medications carts be secured when not attended. The licensee's 2.42 Medication Storage policy dated July 2021 indicated when medications are managed and stored by the licensee, medications will be kept securely locked and stored per	01880		

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01880	Continued From page 43 manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were 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. In addition, the licensee failed to dispose of expired medications. This had a potential to affect all 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 the residents).	01890		

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01890	Continued From page 44 The findings include: On January 14, 2025, at 8:29 a.m., during observation of medication administration the surveyor observed the following: - Timolol Maleate Ophthalmic Solution 0.25% with no opened-on date belonging to R8. On January 16, 2025, at 11:00 a.m., during an audit of the licensee's first floor secured unit medication cart, the surveyor observed the following: - unidentified half of a light blue oval shaped tablet found in the medication drawer outside of its original packaging; - unidentified white round tablet found in the medication drawer outside of its original packaging; - budesonide and formoterol inhaler with no opened-on date belonging to R6; - card of promethazine 25 mg tablets with an expiration date of December 6, 2024, belonging to R11; - card of Hyoscyamine 0.125 mg tablets with an expiration date of December 6, 2024, belonging to R11; and - card of acetaminophen 500 mg tablets with an expiration date of December 25, 2024, belonging to R11. On January 16, 2025, at 11:19 a.m., during an audit of the licensee's second floor medication cart, the surveyor observed the following: - Lantus Solostar 100u/ml injection pen with no opened-on date belonging to R12; - card of acetaminophen 500mg tablets with an expiration date of January 14, 2025, belonging to R14; and - card of loperamide 2mg capsules with an	01890		

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01890	Continued From page 45 expiration date of December 12, 2024, belonging to R13. On January 16, 2025, at 11:03 a.m., clinical nurse supervisor (CNS)-B stated staff were trained to put medications into an envelope when loose medications were found, and to then place the medication in a medication destruction bin and notify the registered nurse so the medications may be identified and destroyed. On January 16, 2025, at 11:16 a.m., CNS-B stated they oversaw managing the medication carts. CNS-B stated the licensee received most of their medications on cycle fill, but that PRN (as needed) medications were sometimes not used as quickly. CNS-B stated there had been some user error on ensuring expired medications were being disposed of. The licensee's 2.42 Medication Storage policy dated July 2021 indicated when medications are managed and stored by the licensee, medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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:	02110		

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02110	Continued From page 46 (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 policies and procedures for assisted living with dementia care (ALFDC) were provided to residents or the resident's legal and / or designated representative at the time of move-in or at the time they began receiving	02110		

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02110	Continued From page 47 assisted living services for three of four residents (R2, R6, R7). 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). The findings include: R2 admitted to licensee June 17, 2010, under the licensee's former comprehensive license and started receiving assisted living services August 1, 2021. R6 admitted to licensee February 21, 2022, and started receiving assisted living services. R7 admitted to the licensee on September 21, 2021, and started receiving assisted living services. R2, R6, and R7's records lacked evidence the licensee provided a resident or resident representative policies and procedures that addressed 144G.82 Subd. 3., at the time of move-in to the facility or upon conversion to assisted living licensure. On January 15, 2025, at 11:04 a.m., licensed assisted living director (LALD)-A provided a copy of a document titled "Assisted Living with Dementia Care Policies and Procedures". LALD-A stated all residents admitted since they started their current role as LALD on October 23, 2023, had been provided with this document.	02110		

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02110	Continued From page 48 LALD-A stated the licensee would complete an audit of resident records to ensure all residents had recieved proper documentation. On January 16, 2025, at 9:46 a.m., regional director (RD)-H stated that at the time of admit for R2 and R7, the licensee likely did not have the required documentation to be issued at the time of move-in. RD-H stated the licensee did have the documentation available for current admissions. RD-H stated they planned to reissue the policies and procedures to previously admitted residents or the resident's legal and / or designated representatives. The licensee's Dementia Program Disclosure Requirements policy dated January 2017 indicated the licensee would make appropriate disclosures to clients and client representatives in relation to our dementia program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to	02240		

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02240	Continued From page 49 file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written acknowledgement of receipt of the current assisted living bill of rights was obtained for three	02240		

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02240	Continued From page 50 of three residents (R2, R6, and R7). 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). The findings include: R2 R2 admitted to licensee June 17, 2010, under the licensee's former comprehensive license and started receiving assisted living services August 1, 2021. R2's record included acknowledgement of receiving the Home Care Bill of Rights dated June 17, 2020, however, it lacked written acknowledgement that they received the current Minnesota Bill of Rights for Assisted Living Residents, as required. R6 R6 admitted to licensee February 21, 2022, and started receiving assisted living services. R6's record included acknowledgement of receiving the Home Care Bill of Rights dated May 19, 2022, however, it lacked written acknowledgement that they received the current Minnesota Bill of Rights for Assisted Living Residents, as required. R7 R7 admitted to the licensee on September 21, 2021, and started receiving assisted living	02240		

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02240	Continued From page 51 services. R7's record included acknowledgement of receiving the Home Care Bill of Rights dated September 22, 2021, however, it lacked written acknowledgement that they received the current Minnesota Bill of Rights for Assisted Living Residents, as required. On January 16, 2025, at 9:46 a.m., regional director, (RD)-H stated at the time of admit for R2, R6, and R7, the licensee likely did not have the required documentation to be issued at the time of move-in. RD-H stated the licensee did now have the documentation available for current admissions. RD-H stated they would ensure that the assissted living bill of rights would be reissued to residents or the resident's legal and / or designated representatives. The licensee's Admission Document Receipt form indicated that upon admission the residents or the resident's representative would be provided a copy of the MN Bill of Rights for Assisted Living Residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 52 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of two residents (R2, R6) who utilized hospital bed rails. Additionally, the licensee failed to provide care and services according to acceptable health care standards, medical, or nursing standards for one of one resident (R6) who utilized oxygen. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R2 R2 was admitted to the licensee on June 16, 2020, and began receiving assisted living service on August 1, 2021. R2's diagnoses included adjustment disorder, alcohol dependence, anxiety disorder, bipolar disorder, dementia, major depressive disorder, moderate multiple sclerosis, osteoporosis, personality disorder, and essential hypertension. R2's unsigned service plan, dated January 14, 2025, included full assistance with dressing, full assistance with bathing, two-person assist with toileting, weekly vitals, daily housekeeping	02310		

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ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

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02310	Continued From page 53 services, and assistance with laundry. R2's most recent 90-day assessment dated April 2, 2024, indicated R2 did not utilize a bed rail at the time of the assessment. R2's record contained a document titled, 2.62MN-F Bed Rail Negotiated Risk Agreement dated June 24, 2024, which was utilized by the licensee as bed rail assessment tool. The document contained information regarding bed rail measurements, and risk and benefits disclosure. The record lacked the following required information: - The type of bed rail in use; - Purpose and intention of the bed rail; - Whether the resident is at risk for falls or entrapment; - The resident's bed rail use/need assessment; - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and, - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. R2's record lacked additional bed rail assessments indicating that 205 days had lapsed since the last bed rail assessment. On January 14, 2025, at 7:23 a.m., the surveyor observed a hospital style bed with bed rails firmly attached and in the upright position on each side of R2's bed. R6 R6 was admitted to the licensee on February 21, 2022, to receive assisted living services.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28353	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

(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
02310	Continued From page 54 R6's diagnoses included sepsis, hypomagnesemia, dementia, major depressive disorder, insomnia, Alzheimer's disease, neuro cognitive disorder, chronic systolic heart failure, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, benign essential microscopic hematuria, functional urinary incontinence, history of falling, and presence of cardiac pacemaker. R6's unsigned service plan, dated January 14, 2025, included standby assistance with oral cares, full assistance with dressing, physical assistance with grooming, full assistance with bathing, weekly vitals, assistance with bowel and bladder, medications administration, medications management, oxygen therapy, assistance with wheelchair use, coordination with hospice services, life enrichment, assistance with communication, housekeeping, and laundry assistance. R6's most recent 90-day assessment dated March 28, 2024, indicated that R6 did not utilize a bed rail at the time of the assessment. R6's record contained a document titled, 2.62MN-F Bed Rail Negotiated Risk Agreement dated November 18, 2024, which was utilized by the licensee as bed rail assessment tool. The document contained information regarding bed rail measurements, and risk and benefits disclosure. The record lacked the following required information: - The type of bed rail in use; - Purpose and intention of the bed rail; - Whether the resident is at risk for falls or entrapment; - The resident's bed rail use/need assessment; - The resident's preferences;	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28353	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

(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
02310	Continued From page 55 - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and, - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On January 14, 2025, at 7:52 a.m., the surveyor observed a hospital style bed with bed rails firmly attached and in the upright position on each side of R6's bed. Additionally, the surveyor observed a small oxygen canister stored in the upright position behind R6's bedroom door. The oxygen canister was not stored in a storage rack or secured to the wall. On January 14, 2025, at 2:26 p.m., clinical nurse supervisor (CNS)-B stated that R6 had three oxygen tanks. One was stored in a small, wheeled cart, the second was stored on R6's tank filler, and the third was stored behind the door. CNS-B stated they would contact their supplier to obtain a storage rack for R6. On January 15, 2025, at 12:00 p.m., CNS-B stated there were no other bed rail assessments on file for R2, and they were unaware that bed rails needed to be assessed every 90 days. CNS-B stated regional director (RD)-H would check for recalls on bedrails every 90 days, but the bed rails were not physically assessed every 90 days. The licensee's 2.62MN Bed Rails policy dated December 2022, indicated when bed rails are in use, an RN must conduct an assessment to identify the intended purpose of the bed rail and the risks regarding the use of the bed rail. The RN assessment will be completed upon initial installation, with each 90-day assessment and/or	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28353	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

(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
02310	Continued From page 56 change in condition assessment. The licensee's 2.65 Oxygen Use, Storage and Safety policy dated September 2017 indicated if oxygen cylinders are in use, oxygen cylinders shall be secured in an upright position. If stored upright, cylinders must be secured. If stored horizontally, cylinders shall be on a level surface where they will remain stationary. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "The licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations" and "Best practice for documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Measurements - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28353	A. BUILDING: _____ B. WING _____	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT MAHTOMEDI	720 MAHTOMEDI AVENUE MAHTOMEDI, MN 55115

(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
02310	Continued From page 57 - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended cylinders be secured with chains or racks to prevent cylinders from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *01/14/25*
Time: 12:39:59
Report: 1023251021

Food and Beverage Establishment Inspection Report

Location:
The Encore At Mahtomedi
720 Mahtomedi Avenue
Mahtomedi, MN55115
Washington County, 82

Establishment Info:
ID #: 0038816
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6515288442
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

4-501.11AB

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

REPAIR WALK IN COOLER DOOR SO THAT CLOSING MECHANISM FUNCTIONS AS INTENDED TO ENSURE TIGHT CLOSURE.

Comply By: 01/14/25

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO HAND WASHING SIGNS AT SERVICING AREA SINKS. EACH SERVICING AREA MUST HAVE A SINK BASIN DEDICATED TO HAND WASHING ONLY WITH REMINDER SIGN, SOAP, AND PAPER TOWEL.

Comply By: 01/14/25

Surface and Equipment Sanitizers

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

Hot Water: = at 163 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Type: Full
Date: *01/14/25*
Time: 12:39:59
Report: 1023251021
The Encore At Mahtomedi

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Hold/CHICKEN
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER MAIN KITCHEN
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER MAIN KITCHEN
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER 1ST FLOOR SERVICE AREA
Violation Issued: No

Process/Item: Cold Hold/JUICE
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER 2ND FLOOR SERVICE AREA
Violation Issued: No

Process/Item: Cold Hold/YOGURT
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER 3RD FLOOR SERVICE AREA
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY CONSISTS OF A LOWER LEVEL MAIN KITCHEN WITH COOK LINE BELOW VENTILATION HOOD/ANSUL, DISH MACHINE, THREE COMPARTMENT SINK, PREP SINK, AND ALSO HAS THREE SERVING AREAS EACH WITH A PREP COOLER, COFFEE MACHINE, SINK, AND SNACKS. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- SERVICE GREASE TRAP REGULARLY

EACH OF THE THREE SERVICING AREAS HAS A DOMESTIC TYPE REACH IN COOLER AND A DOMESTIC TYPE DISH WASHER THAT ARE NOT IN USE. INSPECTOR RECOMMENDS REMOVING UNUSED EQUIPMENT.

Type: Full
Date: *01/14/25*
Time: 12:39:59
Report: 1023251021
The Encore At Mahtomedi

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 1023251021 of 01/14/25.

Certified Food Protection Manager: HOLLY TOMPSON

Certification Number: 103229 Expires: 01/14/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
HOLLY TOMPSON
PERSON IN CHARGE

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