DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 10, 2022

Administrator
Savage Senior Living
5950 West 130th Lane
Savage, MN 55378

RE: Project Number(s) SL31696015

Dear Administrator:

On April 28, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the February 16, 2022, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

Electronically Delivered

March 14, 2022

Administrator
Savage Senior Living
5950 West 130th Lane
Savage, MN 55378

RE: Project Number(s) SL31696015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on February 16, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

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

The correction order documentation should include the following:

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

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

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

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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31696	A. BUILDING: _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVAGE SENIOR LIVING	5950 WEST 130TH LANE SAVAGE, MN 55378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#31696015 On February 14, through February 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were residents 90; 47 receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 14, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 510	Continued From page 2	0 510		
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 infection control program that complies with accepted health care, medical and nursing standards for infection control, and for current conditions of COVID-19. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 15, 2022, at 8:00 a.m., unlicensed	0 510		

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0 510	Continued From page 3 personnel (ULP-K) walked out of a room with a resident. ULP-K's face shield was on, but mask was below her nose. ULP-K confirmed that mask should be worn above her nose but stated "it was hot." On February 15, 2022, at 8:50 a.m., ULP-K wore her mask below her nose while assisting with serving breakfast to the residents in the dining room. On February 16, 2022, at 11:50 a.m., ULP-K wore her mask below her nose while serving lunch to the residents. On February 16, 2022, at 1:15 p.m., ULP-K wore her mask below her nose while pushing a resident's wheelchair to the elevator. On February 16, 2022, at 8:20 a.m., director of nursing (DON)-C confirmed that staff are required to wear goggles and face masks. The licensee's PPE using Masks and Eye Protection policy, dated November 21, 2021, indicated that all staff are required to wear eye protection and face masks when in contact with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance	0 550		

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0 550	Continued From page 4 procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information related to the grievance procedure, resident advocacy information, and information for reporting suspected maltreatment. 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). The findings include: On February 14, 2022, at approximately 11:00 a.m., the surveyor did not observe the licensee's grievance procedure, resident advocacy information, or information for reporting suspected maltreatment posted in any area of the licensee's facility. The licensee lacked postings in a conspicuous location and a disclosure of resident advocacy to include:	0 550		

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0 550	Continued From page 5 -a posting with all required content of the licensee's grievance procedure and the name and email contact information for the individuals who are responsible for handling grievances. -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and -number and contact information and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On February 14, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-E confirmed the required content was not posted. The licensee's Grievances policy, dated August 2021, failed to note that the licensee would post in a conspicuous place information about the licensee's grievance procedure, and the name, telephone number, and e-mail contact for the individuals responsible for handling resident grievances. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by	0 640		

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0 640	Continued From page 6 the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living and the Minnesota Adult Abuse Reporting Center (MAARC) information to report suspected maltreatment of a vulnerable adult under section 626.557. 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 February 14, 2022, at approximately 11:00 am, the surveyor observed, along with licensed assisted living director (LALD)-E and regional operations director (RO)-F, the common areas on the licensee's main level. The surveyor observed no postings containing the 911 emergency number or MAARC contact and reporting information. On February 14, 2022, at approximately 11:00 am	0 640		

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0 640	Continued From page 7 LALD-E confirmed the content noted above was not posted. LALD-E stated she was unaware of the requirement to have the 911 emergency number nor any MAARC reporting or contact information posted on or near any of the common areas frequented by residents, staff, or visitors. LALD-E indicated they recently put up a wall outside the elevator and wanted to know if that location would work. The licensee's Grievances policy, dated August 2021, failed to note that the licensee would post in the licensee's common areas and near community telephones information for reporting suspected maltreatment to MAARC and the 911 emergency number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and	0 680		

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0 680	Continued From page 8 (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to post an emergency disaster plan prominently visible to all. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 14, 2022, at approximately 11:00 a.m., the surveyor requested to view the licensee's emergency preparedness plan. The licensee's plan consisted of several documents and policies contained in a red	0 680		

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0 680	Continued From page 9 three-ringed binder titled "Emergency Preparedness Manual." The binder included a risk assessment, a communication plan, various policies/procedures, and after-action reviews. The licensee completed a written emergency disaster plan and posted emergency exit diagrams on each floor. The licensee failed to post the emergency disaster plan. On February 14, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-E indicated she was familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). LALD-E acknowledged they had not posted the emergency disaster plan. The licensee lacked a policy on posting the emergency disaster plan prominently visible to all. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 10 Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of 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). Findings include: On a facility tour with the Director of Environmental Services (DES-E), Executive Director (LALD-E), and Regional Operations Director (RO-F) on February 15, 2022, between approximately 10:45 a.m. and 2:15 p.m., it was observed that the stored furnace filters were obstructing the sprinkler head in the third-floor mechanical room. Obstructions will inhibit the ability of the sprinkler head to respond as designed in the event of a fire. It was observed that room #414 lacked a carbon monoxide detector. It appears it was incorrectly replaced by a smoke alarm without carbon monoxide detection. It was observed that the trash chute door on the third floor did not close or positively latch. The trash chute door is required to automatically close	0 800		

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(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
0 800	Continued From page 11 and latch to maintain fire integrity of the trash chute that connects all levels of the facility. It was observed that room #317 had incorrectly installed a smoke alarm with a carbon monoxide detector in the sleeping room and not in the area immediately outside the sleeping room. The area immediately outside the sleeping room had a smoke alarm only, so the two devices should be switched to be in compliance. These deficient conditions were visually verified by DES-E, LALD-E, and RO-F accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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	31696	A. BUILDING: _____ B. WING _____	02/16/2022

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0 810	Continued From page 12 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, 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). Findings include: A record review and interview were conducted on February 15, 2022, between approximately 10:00 a.m. and 10:45 a.m. with the Director of Environmental Services (DES-E), Executive	0 810		

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0 810	Continued From page 13 Director (LALD-E), and Regional Operations Director (RO-F) on the fire safety and evacuation plan and fire safety and evacuation training and drills for the facility. Record review indicated that employees received training annually on the facility fire safety and evacuation plan and not twice per year after initial hire. During interview, RO-F stated that the company policy had been updated to state that employees are required to be trained twice per year after initial hire to meet the statutory requirement, but this policy had not been updated at this facility at the time of survey. LALD-E verified that this policy had not been updated at this site at this time. Record review indicated that that the licensee did not have documentation indicating that evacuation drills had been conducted every other month as required. During interview, RO-F stated that the licensee had not conducted any evacuation drills to date and that they were working to update the policy and process for these required drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE	0 950		

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0 950	Continued From page 14 FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representatives' statutory language for five of five residents (R1, R2, R3, R4, and R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 950		

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0 950	Continued From page 15 The findings include: R1, R2, R3, R4, and R5's record lacked verbatim notice for designated representative. R1's Master Assisted Living Resident Agreement dated July 23, 2021, lacked verbatim notice for designated representative. R2's Master Assisted Living Resident Agreement dated July 21, 2021, lacked verbatim notice for designated representative. R3's Master Assisted Living Resident Agreement dated July 28, 2021, lacked verbatim notice for designated representative. R4's Master Assisted Living Resident Agreement dated February 11, 2021, lacked verbatim notice for designated representative. R5's Master Assisted Living Resident Agreement dated January 1, 2021, lacked verbatim notice for designated representative. On February 14, 2022, at approximately 10:00 a.m. director of nursing (DON)-C provided a Master Assisted Living Resident Agreement and indicated the form was used for all residents as documentation of resident's designation of representative. Although the form did include a space for residents to decline designation of representative, DON-C acknowledged the verbatim notice is not included with the contract. DON-C stated the notice would need to be provided to all residents in the facility. The licensee lacked a policy or procedure related to contents of an assisted living contract.	0 950		

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0 950	Continued From page 16 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's Master Assisted Living Resident Agreement,	0 970		

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0 970	Continued From page 17 dated July 23, 2021, indicated R1 agreed to the content of the resident handbook. R2's Master Assisted Living Resident Agreement, dated July 21, 2021, indicated R2 agreed to the content of the resident handbook. R3's Master Assisted Living Resident Agreement, dated July 28, 2021, indicated R3 agreed to the content of the resident handbook. R4's Master Assisted Living Resident Agreement, dated February 11, 2021, indicated R4 agreed to the content of the resident handbook. R5's Master Assisted Living Resident Agreement, dated January 1, 2021, indicated R5 agreed to the content of the resident handbook. The licensee's Resident Handbook, dated August 1, 2021, read, "It is strongly recommended that you ensure your insurance coverage protects your personal property, your liability for personal injury or for property damage for which you are responsible," which indicated the licensee was waiving liability of personal property and personal injury to resident. On February 14, 2022, at approximately 11:00 a.m., director of nursing (DON)-C acknowledged the Resident Handbook indicated the resident was liable for personal property and personal injury, not the licensee. DON-C stated they were not aware the facility could not waive liability for resident property or injury. The licensee lacked a policy or procedure related liability waivers. No further information provided.	0 970		

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0 970	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 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;	01370		

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01370	Continued From page 19 (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 technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of one employee (unlicensed personnel (ULP)-B) to include all required content with training record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP- B was hired on October 29, 2019. ULP-B's training record lacked documentation of completed training and competency for maintenance of a clean and safe environment and commonly used assistive devices. On February 15, 2022, at approximately 7:00 a.m., ULP-B stated they were trained by licensee and oriented to the needs of residents. On February 16, 2022, at approximately 11:00 a.m., director of nursing (DON)-C acknowledged	01370		

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01370	Continued From page 20 ULP-B's record lacked documentation of the required training. DON-C stated the training documentation lacking would have been completed onsite during orientation, but documentation was missed due to change of senior leadership during ULP-B's time of hire. The licensee's Orientation and Training: Employee policy, dated August 1, 2021, indicated all required training and documentation of training would be kept in each employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced	01380		

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01380	Continued From page 21 by: Based on interview and record review, the licensee failed to ensure training and competency was completed for one of one employee (unlicensed personnel (ULP)-B) to include all required content with training record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP- B was hired on October 29, 2019. ULP-B's training record lacked documentation of completed training and competency for range of motion/positioning and recognizing physical, emotional, cognitive, and developmental needs of the resident. On February 15, 2022, at approximately 7:00 a.m., ULP-B stated they were trained by licensee and oriented to the needs of residents. On February 16, 2022, at approximately 11:00 a.m., director of nursing (DON)-C acknowledged ULP-B's record lacked documentation of the required training. DON-C stated the training documentation lacking would have been completed onsite during orientation, but documentation was missed due to change of senior leadership during ULP-B's time of hire. The licensee's Orientation and Training:	01380		

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01380	Continued From page 22 Employee policy, dated August 1, 2021, indicated all required training and documentation of training would be kept in each employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	01730		

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management services; and
(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for five of five residents (R1, R2, R3, R4 and R5) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1, R2, R3, R4, and R5's medication management record lacked required content.

On February 15, 2022, at approximately 10:00 a.m., director of nursing (DON)-C indicated

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medication management record contents would be included on each resident's service plan and master assessment.

R1
On February 15, 2022, at approximately 7:00 a.m., ULP-B provided oral medications, nasal spray, inhaler, and eye drops per provider order to R1.

R1 admitted on May 4, 2019, with diagnoses of hypertension (high blood pressure), diabetes type II, and congestive heart failure.

R1's Service Plan, dated September 1, 2021, indicated R1 received medication management services.

R1's Master Assessment 2.0, dated October 14, 2021, indicated R1 requires assistance with medication management.

R1's medication management record lacked:
- Person responsible for monitoring and ordering supplies and refills.
- Medication management tasks delegated to ULPs.

R2
On February 15, 2022, at approximately 7:00 a.m., ULP-B provided oral medications per provider order to R2.

R2 admitted on July 16, 2018, with diagnoses of hypertension (high blood pressure), gout, and osteoarthritis.

R2's Service Plan, dated January 1, 2022, indicated R2 received medication management services.

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01730	Continued From page 25 R2's Master Assessment 2.0, dated December 17, 2021, indicated R2 requires assistance with medication management. R2's medication management record lacked: - Type of medication storage system. - Person responsible for monitoring and ordering supplies and refills. - Medication management tasks delegated to ULPs. R3 R3 admitted on May 19, 2021, with diagnoses of diabetes type II and rotator cuff tear. R3's Service Plan, dated December 7, 2021, indicated R3 received medication management services. R3's Master Assessment 2.0, dated January 27, 2022, indicated R3 requires assistance with medication management. R3's medication management record lacked: - Type of medication storage system. - Person responsible for monitoring and ordering supplies and refills. - Medication management tasks delegated to ULPs. R4 On February 15, 2022, at approximately 8:00 a.m., ULP-J provided oral medications per provider order to R4. R4 admitted on September 9, 2020, with a diagnosis of dementia. R4's Service Plan, dated February 11, 2021,	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31696	A. BUILDING: _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAVAGE SENIOR LIVING	5950 WEST 130TH LANE SAVAGE, MN 55378

(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
01730	Continued From page 26 indicated R4 received medication management services. R4's Master Assessment 2.0, dated January 1, 2021, indicated R4 requires assistance with medication management. R4's medication management record lacked: - Person responsible for monitoring and ordering supplies and refills. - Medication management tasks delegated to ULPs. R5 On February 15, 2022, at approximately 8:00 a.m., ULP-J provided oral medications to R5. R5 admitted on January 16,2017, with diagnoses of dementia and diabetes type II. R5's Service Plan, dated January 1, 2021, indicated R1 received medication management services. R5's Master Assessment 2.0, dated January 1, 2021, indicated R5 requires assistance with medication management. R5's medication management record lacked: - Person responsible for monitoring and ordering supplies and refills. - Medication management tasks delegated to ULPs. On February 16, 2022, at approximately 11:00 a.m., DON-C and licensed assisted living director (LALD)-E acknowledged the required content was lacking from residents' medication management records. LALD-E stated the licensee was transitioning to a new assessment and service	01730		

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	31696	A. BUILDING: _____ B. WING _____	02/16/2022

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01730	Continued From page 27 plan and had not implemented the new documents that contained the required content. LALD-C stated the lacking content would not be present in any resident record as service plans and master assessments were similar for each resident. The licensee's Medication Management Services policy, dated August 1, 2021, indicated the required content would be included in the resident's records. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an opened medication was dated correctly for one of five residents (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01890		

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	31696	A. BUILDING: _____ B. WING _____	02/16/2022

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01890	Continued From page 28 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On February 16, 2022, at approximately 8:15 a.m., unlicensed personnel (ULP)-J prepared insulin according to the electronic medical record for R5. The open insulin pen lacked a label of the date it was opened. ULP-J verified the insulin pen should have been dated when opened and removed an unmarked open insulin pen. On February 16, 2022, at approximately 11:15 a.m., registered nurse (RN)-C acknowledged insulin pens should be dated at the time of opening. The licensee's Medication Administration: insulin pen injection policy, dated August 1, 2021, indicated when opening a new insulin pen, staff should put the current date and initials. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current	01940		

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	31696	A. BUILDING: _____ B. WING _____	02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
01940	Continued From page 29 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized treatment management record to include all required content for two of two residents (R1 and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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	01940		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01940	Continued From page 30 of the residents). The findings include: On February 15, 2022, at approximately 10:00 a.m. director of nursing (DON)-C indicated treatment management record contents would be included on each resident's service plan and master assessment. R1 On February 15, 2022, at approximately 7:00 a.m. ULP-B performed blood glucose check treatment per provider order for R1. R1 admitted on May 4, 2019, with diagnoses of hypertension (high blood pressure), diabetes type II, and congestive heart failure. R1's Service Plan dated September 1, 2021, indicated R1 received, "Glucose Check Assist - Treatme (sic)." R1's Master Assessment 2.0 dated October 14, 2021, indicated " Cue FSBS 2 x daily." R1's treatment management record lacked: - Written instructions for the treatment. - Resident specific instructions related to treatments received. R3 R3 admitted on May 19, 2021, with diagnoses of diabetes type II and rotator cuff tear. R3's Service Plan dated December 7, 2021, indicated R2 received, "Glucose Check Assist - Treatme (sic)." R3's Master Assessment 2.0 dated January 27,	01940		

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	31696	A. BUILDING: _____ B. WING _____	02/16/2022

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01940	Continued From page 31 2022, indicated "Ebenezer ULP to cue for glucose check, resident can perform independently 3 x daily." R3's treatment management record lacked: - List of treatments to be delegated to ULPs. On February 16, 2022, at approximately 11:00 a.m. DON-C and licensed assisted living director (LALD)-E acknowledged the required content was lacking from residents' treatment management records. LALD-E stated the licensee was transitioning to a new assessment and service plan and had not implemented the new documents that contained the required content. DON-C stated the lacking content would not be present in any resident record as service plans and master assessments were similar for each resident. The licensee's Development of Individualized Treatment Management Plan policy dated August 1, 2021, indicated the required content would be included in the resident's records. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the	02040		

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02040	Continued From page 32 property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, 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). Findings include: A record review and interview were conducted on February 15, 2022, between approximately 10:00 a.m. and 10:45 a.m. with the Director of Environmental Services, Executive Director, and Regional Operations Director on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, RO-F stated that the licensee had performed a hazard assessment for the Appendix	02040		

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02040	Continued From page 33 Z requirements but had not performed a hazard vulnerability assessment being performed for the physical environment on or around the property due to some confusion around the requirements and statute. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and	02110		

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02110	Continued From page 34 evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living facility with dementia care provided the required policies and procedures to five of five residents (R1, R2, R3, R4, and R5) with records reviewed. 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: On February 14, 2022, at approximately 10:00 a.m., during the entrance conference, director of nursing (DON)-C and licensed assisted living director (LALD)-E acknowledged the licensee operated under an assisted living facility with dementia care license as of August 1, 2021. R1 admitted on May 4, 2019. R1's record lacked documentation for receipt of required policies and procedures to be provided at the time of move-in to the facility.	02110		

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02110	Continued From page 35 R2 admitted on July 16, 2018. R2's record lacked documentation for receipt of required policies and procedures to be provided at the time of move-in to the facility. R3 admitted on May 19, 2021. R3's record lacked documentation for receipt of required policies and procedures to be provided at the time of move-in to the facility. R4 admitted on September 1, 2020. R4's record lacked documentation for receipt of required policies and procedures to be provided at the time of move-in to the facility. R5 admitted on January 16, 2017. R5's record lacked documentation for receipt of required policies and procedures to be provided at the time of move-in to the facility. On February 16, 2022, at approximately 11:00 a.m., DON-C and LALD-E acknowledged residents' records lacked documentation residents were provided the required policies and procedures at move in or initiation of the assisted living facility with dementia care license. Although LALD-E provided a packet with all required policies and procedures, the licensee had failed to provide them to the residents and obtain documentation of receipt. The licensee lacked a policy or procedure to provide and document receipt of required policies and procedures provided to residents at the time of move in. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

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03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all residents, staff, and visitors of the licensee. 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 the residents). The findings include: On February 14, 2022, at approximately 11:00 a.m., Minnesota Department of Health (MDH) surveyors entered the assisted living with dementia care facility. The surveyors did not observe signage posted in the licensee's facility regarding electronic monitoring devices.	03090		

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03090	Continued From page 37 On February 14, 2022, at approximately 11:00 a.m., licensed assisted living director (LALD)-E confirmed the content noted above was not posted with the required language. The licensee lacked a policy related to the requirement on electronic monitoring signage No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *02/14/22*
Time: 01:45:01
Report: 8075221037

Food and Beverage Establishment Inspection Report

Location:
Savage Senior Living
5950 West 130th Lane
Savage, MN55378
Scott County, 70

Establishment Info:
ID #: 0038552
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9528088725
ID #:

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

The following orders were issued during this inspection.

3-400A Destroying Organisims: cooking time/temperature, freezing

3-401.11C(1)

MN Rule 4626.0340C(1) Discontinue offering raw or undercooked steak to a highly susceptible population.

Comply By: 02/14/22

Surface and Equipment Sanitizers

Quaternary Ammonium: = 200ppm at Degrees Fahrenheit
Location: wiping cloth sanitizer bucket
Violation Issued: No

Wash Temp: = at 150 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Rinse Temp: = at 188 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Utensil Surface Temp: = at 165 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 166 Degrees Fahrenheit - Location: hot holding unit - scrambled eggs
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 136 Degrees Fahrenheit - Location: hot holding unit - sausage
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk in cooler - casserole
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk in cooler - ground beef
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: walk in cooler - sloppy joe
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: cooler - cut melon
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: cooler - deli meat
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: cooler - egg salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: cooler - ham
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: milk dispenser - milk
Violation Issued: No

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: hot holding unit - soup
Violation Issued: No

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

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 8075221037 of 02/14/22.

Certified Food Protection Manager: Dennis R. Duff

Certification Number: FM28877 Expires: 04/17/22

Signed:_____

Robert Moore
Regional Culinary Director

Signed: Erin Tibbetts

Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
erin.tibbetts@state.mn.us