Electronically Delivered

July 12, 2022

Administrator
The James INC.
10040 Nord Road
Bloomington, MN 55437

RE: Project Number SL33681015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 15, 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, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up 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.

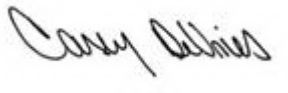
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. 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 be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33681	A. BUILDING: _____ B. WING _____	06/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JAMES INC	10040 NORD ROAD BLOOMINGTON, MN 55437

(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: SL33681015-0 On June 13, 2022, through June 15, 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 five residents, all of whom received services.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed and posted as required, potentially affecting the licensee's five current residents, staff and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	0 470		

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0 470	Continued From page 2	0 470		

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).

The findings include:

STAFF POSTING
On June 13, 2022, at 11:00 a.m. during a tour of the facility, the surveyor observed the main entry area, which lacked the required posting of the staff schedule.

The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to:
- include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked
- identify the direct-care staff member's resident assignments or work location; and
- be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building.

STAFFING PLAN
The licensee failed to develop and implement a staffing plan for determining its staffing level that:
- included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility
- ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and
- ensured that the facility can respond promptly and effectively to individual resident emergencies

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0 470	Continued From page 3 and to emergency, life safety, and disaster situations affecting staff or residents in the facility. On June 13, 2022, at 1:30 p.m., licensed assisted living director (LALD)-B confirmed the staffing schedule was not posted and a staffing plan had not been developed. LALD-B stated he was working on getting a new and better board put up so the postings stay up and he would work on a staffing plan. The licensee's undated Staffing & Scheduling policy indicated, the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United	0 480		

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0 480	Continued From page 4 States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all five residents of 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated June 13, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 490	Continued From page 5	0 490		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities that are based upon individual and group interests or physical, mental, and psychosocial needs. 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	0 490		

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0 490	Continued From page 6 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 included: On June 13, 2022, at 10:00 a.m., during the entrance conference, registered nurse (RN)-A stated there were daily activities for the residents. On June 13, 2022, at 11:00 a.m., during a tour of the facility, the surveyor observed the main entrance area and noted the lack of a daily activity schedule posted. On June 13, 2022, at 1:00 p.m., unlicensed personnel (ULP)-D stated, there was not an activity program scheduled, the residents do what they want such as watching television in the living room or in their private rooms, going for walks or hanging out on the patio. ULP-D stated they also take the residents on outings. On June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B stated there are activities available for the residents. LALD-B verified there was not an activity program developed nor was an activity calendar posted. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 490		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so	0 530		

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0 530	Continued From page 7 is reasonably achievable. Staff, visitors, and other guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a process to include designating a staff person to be responsible for providing assistance and responding to resident council recommendations and grievances. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level one violation (a violation that has not 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 June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B stated they have told the residents they can have a meeting to talk about	0 530		

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0 530	Continued From page 8 what they want. LALD-B verified they have not developed a process for resident councils. The licensee's undated Resident and Family Councils policy indicated, [the facility] will provide residents and families the opportunity, space, and privacy for meetings, as reasonably achievable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 530		
0 540 SS=C	144G.41 Subd. 6 Family councils The facility must provide a family council with space and privacy for meetings, where doing so is reasonably achievable. The facility must designate a staff person who is approved by the family council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the family council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended every request of the council. The facility shall, with the approval of the family council, take reasonably achievable steps to make residents and family members aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a process to include designating a staff person to be responsible for providing assistance and responding to family council recommendations and grievances. This	0 540		

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0 540	Continued From page 9 had the potential to affect all residents receiving assisted living services and their families. This practice resulted in a level one violation (a violation that has not 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 June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B stated they have not established family council meetings. LALD-B explained most of the residents do not have family. The licensee's undated Resident and Family Councils policy stated, [The licensee] would provide residents and families the opportunity, space, and privacy for meetings, as reasonably achievable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 540		
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 procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances.	0 550		

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0 550	Continued From page 10 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 the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's 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) 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: The licensee lacked a posting of the grievance procedure, and the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of 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.	0 550		

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0 550	Continued From page 11 On June 13, 2022, at 11:00 a.m., the surveyor observed the entry area and common areas within the facility and noted there was no required posting of the grievance procedure and contact information for the state and applicable regional Office of the Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On June 13, 2021, at 1:30 p.m., licensed assisted living director (LALD)-B confirmed the required content noted above was not currently posted as required. LALD-B stated he was going to get a new and better board, so the postings stay up. The licensee's undated Complaint/Grievance Posting policy stated, [The licensee] will post, in a conspicuous place, the information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individuals(s) who are responsible for handling resident complaint/grievances. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. 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:	0 640		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE JAMES INC	10040 NORD ROAD BLOOMINGTON, MN 55437

(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
0 640	Continued From page 12 (1) posting the 911 emergency number in common areas and near telephones provided by 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, interview and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all the licensee's 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 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 June 13, 2022, at 11:00 a.m., the surveyor observed the entry area and common areas within the facility and noted there was no required posting of information for reporting suspected crime and maltreatment to include the 911 emergency number and the reporting number for the Minnesota Adult Abuse Reporting Center.	0 640		

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0 640	Continued From page 13 On June 13, 2021, at 1:30 p.m., licensed assisted living director (LALD)-B confirmed the required content noted above was not currently posted. LALD-B stated he was going to get a new and better board, so the postings stay up. The licensee's undated Complaint/Grievance Posting policy indicated, the posting will include information for reporting suspected maltreatment to the Minnesota Adult Abuse Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place	0 650		

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0 650	Continued From page 14 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee, unlicensed personnel (ULP)-C. 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-C began employment on November 28, 2018, to provide direct care services to the licensee's residents. ULP-C's employee record lacked the following: - documentation of annual performance reviews that identified areas of improvement needed and training needs. On June 14, 2022, at 12:15 p.m., licensed assisted living director (LALD)-C verified ULP-B's	0 650		

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0 650	Continued From page 15 record was missing annual performance reviews. LALD-C stated they do annual training. The licensee's undated Employee Records policy indicated, employee records for each person will include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are	0 680		

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0 680	Continued From page 16 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 observation, interview and record review the licensee failed to prominently post the facility's emergency disaster plan. This had the potential to affect all residents, staff, and visitors of the licensee. 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). Findings include: On June 13, 2022, at 11:00 a.m., the surveyor observed the entry area and common areas within the facility and noted there was no required posting regarding the licensee's emergency and disaster plan. On June 13, 2021, at 1:30 p.m., licensed assisted living director (LALD)-B confirmed the emergency disaster plan was not currently posted as required. LALD-B stated he was going to get a new and better board, so the postings stay up. The licensee's undated Disaster Planning and Emergency Preparedness policy stated [The facility] will have in place a general emergency preparedness plan, that is in alignment with	0 680		

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0 680	Continued From page 17 facility's requirement to also comply with CMS Appendix Z. The policy lacked direction to post the emergency plan prominently, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by:	0 780		

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0 780	Continued From page 18 Based on observation and interview, the licensee failed to provide smoke alarms in each sleeping room, on each story and failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On June 14, 2022, between 10:20 a.m. and 11:00 a.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed the following: 1. Upstairs bedroom #1 was unoccupied and had no smoke alarm installed. 2. Upstairs bedroom #2 smoke alarm did not sound when the test button was pushed 3. Upstairs bedroom #3 smoke alarm was chirping and needed a new battery. 4. Basement bedroom #1 smoke alarm did not sound when the test button was pushed. 5. Basement bedroom #2 did not have a smoke alarm installed.	0 780		

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0 780	Continued From page 19 6. Smoke alarms were not interconnected RN-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).	0 800		

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0 800	Continued From page 20 The findings include: On June 14, 2022, from approximately 10:20 a.m. to 11:00 a.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed the following: 1. The right side guardrail on the upper deck was loose and could easily have been broken off. 2. The handle on the patio door was broken off. 3. The entryway of the house had loose and warped flooring where a wall had been removed. The floor in this area was also dipping around an in-floor air duct. 4. Upstairs bedroom #1 was unoccupied and needed to be thoroughly cleaned before a new resident moved in. 5. Upstairs bathroom #1 had three lights that did not turn on. 6. Upstairs bathroom #2 exhaust fan was covered in dust and lint. 7. Basement recreation room had broken glass on the window sill and needed a thorough cleaning. 8. Basement bedroom had water damage on the bulkhead. 9. Basement bathroom had staining and unidentified black build-up on light switches and needed a thorough cleaning. RN-A verbally confirmed survey staff observations during the facility tour. RN-A stated	0 800		

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0 800	Continued From page 21 the deck guardrail was scheduled to be fixed on June 16, 2022. RN-A also stated that the bathroom light bulbs were burned out and would be replaced as soon as possible. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

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0 810	Continued From page 22 (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 provide the required fire safety training and evacuation plans for residents and staff. This has 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On June 14, 2022, from approximately 10:20 a.m. to 11:00 a.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed no posted evacuation plans. RN-A verbally confirmed survey staff observations during the facility tour.] During interview on June 14, 2022, at 11:00 a.m., RN-A stated they have done staff and resident training during evacuation drills. Review of the fire policy showed the following:	0 810		

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0 810	Continued From page 23 1. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 2. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. 3. No fire safety and evacuation plan that showed the location and number of resident rooms. 4. Evacuation drills had been done on 1/04/2022 and 3/23/2022. The frequency of evacuation drills was not in compliance with statute requirements. No further information was provided. 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.	0 900		

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0 900	Continued From page 24 (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: Based on interview and record review, the facility failed to develop and execute an assisted living written contract to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 900		

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0 900	Continued From page 25 The findings include: R1 began receiving assisted living services on December 3, 2020. R1's Service Plan dated December 3, 2020, indicated the resident received services which included medication administration. R1's record lacked an assisted living contract as required. On June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B verified R1's record did not include a current contract. LALD-B stated he thought the old contract was good. LALD-B further stated he would get the contract updated. The licensee's undated Signing an Assisted Living Contract policy indicated, when a prospective resident decides to move into [facility name], a signed Assisted Living contract would be received by the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability	01440		

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01440	Continued From page 26 to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee unlicensed personnel (ULP)-C. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a hire date of November 28, 2018. ULP-C's employee record lacked documentation of direct supervision of performing a delegated	01440		

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01440	Continued From page 27 task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On June 14, 2022, at 8:15 a.m., the surveyor observed ULP-C performing medication administration for R1. On June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B verified ULP-C's employee record lacked documentation of direct supervision. LALD-B stated they did not do the 30-day supervision. The staff get trained by the registered nurse and show competency at that time. He did not know competency had to be repeated within 30 days. The licensee's undated Supervision of Staff-Delegated Services policy indicated, direct supervision of staff performing delegated tasks must be provided with 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=D	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	01620		

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01620	Continued From page 28 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 (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 resident are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01620		

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01620	Continued From page 29 The findings include: R1 was admitted December 3, 2020, and had diagnoses to include depression, alcohol dependence, and kleptomania and received services to include medication management. On June 14, 2022, the surveyor reviewed R1's record and found a nursing assessment, in the form of a note, was completed on December 3, 2020. No further nursing assessments were found. On June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B verified the lack of nursing assessments in R1's record and stated they were trying to learn to use RTasks (an electronic record) for assessments and they were going to use the uniform assessment tool to complete assessments. The licensee's undated Assessments, Reviews & Monitoring policy 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		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 30 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident service plans included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01650		

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01650	Continued From page 31	01650		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).
The findings include:
R1's service plan agreement dated December 3, 2020, lacked the following:
-the fees for services;
-the frequency of each service according to the resident's current assessment and resident preferences;
-the identification of staff or categories of staff who will provide the services;
-the schedule and methods of monitoring assessments of the resident;
-the schedule and methods of monitoring staff providing services;
-the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and
-the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.

On June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B verified R1's service plan lacked all the required content. LALD-B stated they were trying to learn to use the RTasks (electronic charting software) system.

The licensee's undated Service Plan policy indicated, all residents receiving assisted living services will have a service plan in place. A

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01650	Continued From page 32 service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences. b. Fees for services to be provided. c. The frequency of each service to be provided based on the most recent assessment and resident preferences. d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring. f. A schedule and method for the next planned monitoring of staff providing services. g. A contingency plan that includes: i. Actions [the facility] will take if scheduled services cannot be provided. ii. Information regarding how the resident can contact [the facility]. iii. The names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition. iv. Identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency. v. How the facility will support documented resident health care directive decisions, if any- including circumstances when emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to	01700		

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providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.
(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an assessment to determine what medication management services would be provided, and how the medication services would be provided for one of one resident (R1).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and

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01700	Continued From page 34 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 13, 2022, the surveyor reviewed R1's medical record. R1 was admitted to the facility on December 3, 2020. R1 received services to include medication administration, meal preparation, and behavior management. R1's record lacked a medication assessment. On June 15, 2022, licensed assisted living director (LALD)-B confirmed a medication assessment had not been completed for R1 and stated they were trying to learn how to use RTasks (electronic charting software) to complete assessments. The licensee's undated Medication Management-Assessment, Monitoring & Reassessment policy indicated [The facility] will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and	01710		

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01710	Continued From page 35 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 interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication re-assessments for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 13, 2022, the surveyor reviewed R1's medical record. R1 was admitted to the facility on December 3, 2020. R1 received services to include medication administration, meal preparation, and behavior management. R1's record lacked an annual medication reassessment. On June 15, 2022, licensed assisted living director (LALD)-B confirmed a medication reassessment had not been completed for R1 and stated they were trying to learn how to use RTasks (electronic charting software) to complete all assessments.	01710		

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01710	Continued From page 36 The licensee's undated Medication Management-Assessment, Monitoring & Reassessment policy indicated [the facility] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and at a minimum, annually. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	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	01730		

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01730	Continued From page 37 personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication 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 interview and record review, the licensee failed to complete an individualized medication management plan with required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 13, 2022, the surveyor reviewed R1's medical record. R1 was admitted to the facility on December 3, 2020. R1 received services to include medication administration, meal	01730		

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01730	Continued From page 38 preparation, and behavior management. R1's record lacked a medication management plan. On June 15, 2022, licensed assisted living director (LALD)-B confirmed R1's record lacked a medication management plan and stated they were trying to learn how to use RTasks (electronic charting software) to complete all assessments and plans. The licensee's undated Medication Management Individualized Plan policy indicated, [The facility] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate health professional when a problem arises with medication management services, and g. 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.	01730		

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01730	Continued From page 39 No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure prescriber orders were transcribed accurately for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01760		

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01760	Continued From page 40 The findings include: On June 14, 2022, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's medications. R1 had diagnoses including major depression, alcohol dependence and kleptomania. R1's pharmacy medication list dated November 23, 2020, included the following scheduled medications: Geri-kot 8.6 mg tablet-take 1 tablet by mouth twice a day; methocarbamol 750 mg tablet- take 1 tablet by mouth every 8 hours; acetaminophen 325 mg tablet- Take 2 tablets (650mg) by mouth every 6 hours as needed for mild or moderate pain; oxybutynin chloride ER 15 mg tablet, extended release 24 hr (hour)- take 1 tablet by mouth every night at bedtime; albuterol sulfate HFA 90 mcg- Inhale 2 puffs every 4 hours as needed (shortness of breath) may have on person; amlodipine 10 mg tablet- take 1 tablet (10 mg) by mouth daily; diclofenac sodium gel 1% 100 gm- apply 4 grams to skin 4 times a day; folic acid 1 mg tablet- take 1 tablet (1 mg) by mouth daily; vitamin B-1 100 mg tablet- take 1 tablet (100 mg) by mouth daily; dorzolamide 2% timolol 0.5% eye drops- place 1 drop by otic (administration to or by way of the ear) route 2 times per day; latanoprost 0.005% eye drops- instill 1 drop by ophthalmic (administration of a drug to the eyes) route 1 time per day into affected eye(s) in the evening; sennosides 8.6 mg tablet- take 1 tablet by oral	01760		

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	33681	A. BUILDING: _____ B. WING _____	06/15/2022

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01760	Continued From page 41 route 2 times per day; gabapentin 300 mg capsule- take 3 capsules by oral route 3 times per day; adult aspirin EC low strength 81 mg tablet delayed- take 1 tablet (81 mg) by mouth daily; atorvastatin 80 mg tablet- take 1 tablet by oral route at bedtime; hydroxyzine HCL 50 mg tablet-take 2 tablet by oral route at bedtime; loratadine 10 mg tablet- take 1 tablet by oral route 1 time per day; sertraline 100 mg tablet- take 2 tablets by oral route at bedtime; trazodone 300 mg tablet- take 1 tablet by oral route 1 time per day at bedtime; NicoDerm CQ 21 mg/24 hour daily transdermal patch- apply 1 patch once daily as needed; NicoDerm 7 mg/24-hour transdermal patch (inactive)- apply 1 patch once daily as needed; polyethylene glycol 3350 17 gram/dose oral powder- take 1 unit by oral route as needed; hydroxyzine HCL 50 mg tablet-take 2 tablets by oral route at bedtime; adult one daily multivitamin 0.4 mg tablet- take 1 tablet by mouth daily; allergy (diphenhydramine) 25 mg tablet- take 2 tablets by mouth as needed; anti-diarrheal (loperamide) 2 mg tablet- take 2 tabs by oral route as needed; calcium carbonate 500 mg calcium (1,250 mg) chewable tablet- chew 2 tabs up to four times daily as needed; cough drops 5 mg- take 1 lozenge as needed for cough; docusate sodium 100 mg capsule- take 1 capsule by mouth twice daily as needed; guaifenesin 100 mg/5 mL oral liquid- take 20 ml every 4 hours as needed; Nicorette 2 mg gum/lozenge- follow package instructions as needed;	01760		

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01760	Continued From page 42 Nicorette 4 mg gum/lozenge- follow package directions as needed; and Xarelto 20 mg tablet- take 1 tablet (20 mg) by mouth daily with evening meal. R1's medication administration record (MAR) for June 2022 showed the following: trazodone 300 mg tab- take 1 tablet by mouth at bedtime; sertraline 100 mg tab- take 2 tablets by mouth at bedtime; loratadine 10 mg tab- take 1 tablet by mouth daily; atorvastatin 80 mg- take 1 tablet by mouth at bedtime; hydroxyzine HCL 50 mg tab- take 2 tablets by mouth every night at bedtime; geri-kot 8.6 mg tab- take 1 tablet by mouth twice a day as needed; Xarleto 20 mg tab- take 1 tablet (20 mg) by mouth daily with meal; aspirin low 81 mg EC tab- take 1 tablet (81 mg) by mouth daily; vitamin B1 100 mg tab- take 1 tablet (100 mg) by mouth daily; folic acid 1000 mcg tab- take 1 tablet (1 mg) by mouth daily; amlodipine 10 mg tab- take 1 tablet (10 mg) by mouth daily; Lidoderm 5% dis- use as directed for pain related to herpes zoster; voltaren 1% gel- apply four grams to skin four times a day; methocarbamol 750 mg tab- take 1 tablet by mouth every 8 hours; naltrexone 50 mg tab- take 1 tablet by mouth daily; pantoprazole 40 mg tab- take 1 tablet by mouth twice a day;	01760		

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01760	Continued From page 43 myrbetriq 25 mg tab- take 1 tablet by mouth daily; nicotine TD 7 mg/24 hour dis- apply 1 patch to skin daily; pregabalin225 mg cap- take 1 capsule by mouth twice a day; Ventolin HFA aerosol- inhale 2 puffs every four hours as needed; acetam 325 mg tab- take 2 tablets (650 mg) by mouth every 6 hours as needed; and nicotrol NS 10 mg/ml spray- use 1 spray in each nostril every 1 to 2 hours as needed. On June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B verified they needed to get updated orders from the doctor but stated they were sure R1 was getting the correct medications because the pharmacy always had the most up to date orders from the doctor and those were the medications that get sent out. LALD-B stated the most current information they had was in the chart. The licensee's undated Medication and Treatment Orders policy indicated, to ensure a current, written prescriber's order must be obtained for any treatment or medication administration provided to a resident. Prescriptions or orders that are to be implemented must be received from an authorized prescriber. And, to ensure ongoing evaluation of medications and treatments. The licensee's undated Medication Management Individualized Plan policy indicated, medication reconciliation will be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. No further information was provided.	01760		

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01760	Continued From page 44 TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). Findings include: R1's record lacked medication set-up documentation to include dates of medication setup, names of medications, quantity of doses, times to be administered, routes of administration and name of person completing medication setup. R1's Service Plan dated December 3, 2020, indicated R1 received medication set up.	01770		

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01770	Continued From page 45 On June 14, 2022, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications. On June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B confirmed the licensee provided weekly medication set-up services. LALD-B stated the nurse used the medication administration record to set up the medications. LALD-B stated he did not know the medication setup needed to be documented. The licensee's undated Medication Management-Dosage Box Setup policy indicated, a licensed nurse will assure the medication orders are transcribed onto the Medication Administration Record (MAR). This profile includes: a. dates of medication setup b. Medication name c. Quantity of dose d. Times to be administered e. Route of administration e. Visual description of medication f. Drug classification and special precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written	01790		

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01790	Continued From page 46 information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before	01790		

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01790	Continued From page 47 the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed a comprehensive written procedure for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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 the residents). The findings include: On June 13, 2022, at 10:00 a.m., registered nurse (RN)-A stated the licensee provided medication management services. On June 15, 2022, licensed assisted living director (LALD)-B confirmed the lack of a written	01790		

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01790	Continued From page 48	01790		

procedure for resident unplanned time away. LALD-B stated the nurse usually did it, but if unlicensed personnel (ULP) had to do it, the RN walked them through it over the phone.

The licensee's undated Medication Management - Planned and Unplanned Time Away policy indicted, for unplanned time away when the pharmacy was not able to provide the medications, a licensed nurse or properly trained and competency tested ULP may give the resident or resident's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven (7) calendar days. For unplanned resident time away when a pharmacist or licensed nurse was not available, the RN may delegate this task to ULP if the RN has developed written procedures for the ULP.

The licensee's policy lacked the written procedure to include the type of container or containers to be used for the medications appropriate to the provider's medication system, how the container or containers must be labeled, written information about the medications to be provided, and how the ULP must document in the resident's record that medications have been provided, including the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative, a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the ULP, and how the ULP must

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01790	Continued From page 49 document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain current medication orders for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 14, 2022, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R1.	01820		

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01820	Continued From page 50 R1's service plan, dated December 3, 2020, indicated R1 received medication administration services. R1 had diagnoses including major depression, alcohol dependence and kleptomania. R1's pharmacy medication list dated November 23, 2020, included the following scheduled medications: Geri-kot 8.6 mg tablet-take 1 tablet by mouth twice a day; methocarbamol 750 mg tablet- take 1 tablet by mouth every 8 hours; acetaminophen 325 mg tablet- Take 2 tablets (650mg) by mouth every 6 hours as needed for mild or moderate pain; oxybutynin chloride ER 15 mg tablet, extended release 24 hr- take 1 tablet by mouth every night at bedtime; albuterol sulfate HFA 90 mcg- Inhale 2 puffs every 4 hours as needed (shortness of breath) may have on person; amlodipine 10 mg tablet- take 1 tablet (10 mg) by mouth daily; diclofenac sodium gel 1% 100 gm- apply 4 grams to skin 4 times a day; folic acid 1 mg tablet- take 1 tablet (1 mg) by mouth daily; vitamin B-1 100 mg tablet- take 1 tablet (100 mg) by mouth daily; dorzolamide 2% timolol 0.5% eye drops- place 1 drop by otic (administration to or by way of the ear) route 2 times per day; latanoprost 0.005% eye drops- instill 1 drop by ophthalmic (administration of a drug to the eyes) route 1 time per day into affected eye(s) in the evening; sennosides 8.6 mg tablet- take 1 tablet by oral	01820		

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01820	Continued From page 51 route 2 times per day; gabapentin 300 mg capsule- take 3 capsules by oral route 3 times per day; adult aspirin EC low strength 81 mg tablet delayed- take 1 tablet (81 mg) by mouth daily; atorvastatin 80 mg tablet- take 1 tablet by oral route at bedtime; hydroxyzine HCL 50 mg tablet-take 2 tablets by oral route at bedtime; loratadine 10 mg tablet- take 1 tablet by oral route 1 time per day; sertraline 100 mg tablet- take 2 tablets by oral route at bedtime; trazodone 300 mg tablet- take 1 tablet by oral route 1 time per day at bedtime; Nicoderm CQ 21 mg/24 hour daily transdermal patch- apply 1 patch once daily as needed; Nicoderm 7 mg/24 hour transdermal patch (inactive)- apply 1 patch once daily as needed; polyethylene glycol 3350 17 gram/dose oral powder- take 1 unit by oral route as needed; hydroxyzine HCL 50 mg tablet-take 2 tablets by oral route at bedtime; adult one daily multivitamin 0.4 mg tablet- take 1 tablet by mouth daily; allergy (diphenhydramine) 25 mg tablet- take 2 tablets by mouth as needed; anti-diarrheal (loperimide) 2 mg tablet- take 2 tabs by oral route as needed; calcium carbonate 500 mg calcium (1,250 mg) chewable tablet- chew 2 tabs up to four times daily as needed; cough drops 5 mg- take 1 lozenge as needed for cough; docusate sodium 100 mg capsule- take 1 capsule by mouth twice daily as needed; guaifenesin 100 mg/5 mL oral liquid- take 20 ml every 4 hours as needed; Nicorette 2 mg gum/lozenge- follow package instructions as needed;	01820		

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01820	Continued From page 52 Nicorette 4 mg gum/lozenge- follow package directions as needed; and Xarelto 20 mg tablet- take 1 tablet (20 mg) by mouth daily with evening meal. On June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B verified the medication orders in R1's record were the most current. LALD-B stated sometimes orders did not get signed by the doctor and they needed to get updated orders. The licensee's undated Medication & Treatment Orders-Renewal policy indicated, residents who receive medication management services by [the facility] will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01820		
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	01890		

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01890	Continued From page 53 review, the licensee failed to ensure medications included the expiration date for time sensitive medications for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On June 15, 2022, at 8:15 a.m., the surveyor reviewed the medication cabinet and observed the following: The following medications were not labeled with an opened date and were found to be expired: - diclofenac 1% topical- pharmacy label indicated discard by 6/8/21 -calmoseptine ointment- expiration date 11/6/21 On June 15, 2022, at 8:25 a.m., licensed assisted living director (LALD)-B stated staff have been trained to label medications when they are opened, it was an oversight. LALD-B stated they would dispose of expired medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors	03090		

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THE JAMES INC	10040 NORD ROAD BLOOMINGTON, MN 55437

(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
03090	Continued From page 54 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 and interview, the licensee failed to ensure the required notice was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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 June 13, 2022, at 9:45 a.m., upon entrance to the facility, the surveyor observed the lack of an electronic monitoring notice to visitors posted. On June 13, 2022, at 1:30 p.m., licensed assisted living director (LALD)-B confirmed the required electronic monitoring sign was not posted. LALD-B stated he was getting a new and better	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33681	A. BUILDING: _____ B. WING _____	06/15/2022

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03090	Continued From page 55 board, so the postings stay up. The licensee's undated Electronic Monitoring policy indicated, signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." 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: *06/13/22*
Time: 14:18:13
Report: 1021221174

Food and Beverage Establishment Inspection Report

Location:
The James Inc
10040 Nord Road
Bloomington, MN55437
Hennepin County, 27

Establishment Info:
ID #: 0037872
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9528314591
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH NURSE. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 06/13/22

2-500 Responding to contamination events

2-501.11 ** Priority 2 **

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

ESTABLISHMENT DOES NOT HAVE PROCEDURES IN PLACE TO CLEAN UP A VOMITING/FECAL ACCIDENT. FACT SHEET SENT WITH REPORT. TRAIN EMPLOYEES ON HOW TO PROPERLY CLEAN UP A VOMITING/FECAL ACCIDENT AS DESCRIBED IN RULE ABOVE.

Comply By: 06/20/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

THE FOOD THERMOMETER ON-SITE IS A DIAL THERMOMETER AND IT HAS A BIG PROBE FOR MEATS AND ROASTS. PROVIDE A FOOD THERMOMETER AS DESCRIBED IN RULE

ABOVE.
Comply By: 06/20/22

4-300 Equipment Numbers and Capacities
4-302.13B ** Priority 2 **
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE. THERMOLABELS WERE LEFT ON-SITE. SEE COMMENTS.
Comply By: 06/20/22

4-300 Equipment Numbers and Capacities
4-302.14 ** Priority 2 **
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE . PROVIDE AS DESCRIBED IN RULE ABOVE.
Comply By: 06/20/22

5-200C Plumbing: Maintenance, fixture location
5-205.11AB ** Priority 2 **
MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.
DIRTY DISHES WERE PLACED IN THE HANDWASHING SIDE OF THE TWO COMPARTMENT SINK. THE HANDWASHING SINK IS ONLY FOR THE WASHING OF HANDS.
Comply By: 06/13/22

2-100 Supervision
2-102.12AMN
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) WAS EMPLOYED AT THIS ESTABLISHMENT. INFORMATION ON HOW TO OBTAIN CFPM CERTIFICATE SENT WITH REPORT.
Comply By: 07/13/22

3-500A Microbial Control: cooling
3-501.13ABC
MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.
A BAG OF FROZEN VEGGIES FOUND THAWING AT ROOM TEMPERATURE IN THE FOOD PREPARATION COMPARTMENT OF THE TWO COMPARTMENT SINK. DISCUSSED WITH

NURSE APPROVED METHODS TO THAW FOOD. COMPLY WITH RULE ABOVE.
Comply By: 06/13/22

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.

PER CONVERSATION WITH NURSE, THE DISH MACHINE IS NOT WORKING. STAFF ARE WASHING AND SANITIZING IN THE TWO COMPARTMENT SINK. REPAIR DISH MACHINE. SEE COMMENTS.
Comply By: 06/20/22

4-600 Cleaning Equipment and Utensils

4-601.11C

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

ACCUMULATION OF GREASE BELOW THE MICROWAVE (THE MICROWAVE THAT IS ABOVE THE STOVE TOP). CLEAN MICROWAVE FILTERS AND AROUND STOVE. CLEAN AND MAINTAIN CLEAN.
Comply By: 06/17/22

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

KITCHEN HANDWASHING SINK IS MISSING A HANDWASHING SIGN OR POSTER THAT REMIND FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.
Comply By: 06/16/22

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	5	5

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH REGISTERED NURSE, JOY POPE AND HEALTH REGULATION DIVISION NURSE EVALUATOR, WENDY ROBARGE.

PER CONVERSATION WITH JOY, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE THERMOLABELS WILL HELP THE ESTABLISHMENT VERIFY THAT THEIR DISH MACHINE IS PROVIDING A FINAL UTENSIL SURFACE TEMPERATURE OF 160F OR ABOVE.

CONTINUATION OF MN Rule 4626.0735AB

ONE COMPARTMENT OF THE TWO COMPARTMENT SINK HAS BEEN ASSIGNED AS A HANDWASHING SINK AND THE OTHER AS A PREPARATION SINK. SINCE THE DISH

Food and Beverage Establishment Inspection Report

MACHINE IS NOT WORKING, STAFF ARE USING THE HANDWASHING SIDE TO WASH AND RINSE DISHES/UTENSILS AND THEY ARE FILLING A TUB WITH CHLORINE AND WATER TO SANITIZE.

THE DISH MACHINE ON-SITE DOES MEET THE RESIDENTIAL NSF/ANSI 184 STANDARD.

CONTINUATION OF MN Rule 4626.1620

DISCUSSED WITH JOY THE APPROVED TYPES OF CHLORINE SANITIZER FOR FOOD CONTACT SURFACES. MAKING SURE THAT THE LABEL MENTIONS THAT IT CAN BE USED WITH NONPOROUS FOOD CONTACT SURFACES.

THE KITCHEN HAS WOOD CABINETS, LAMINATE COUNTERS, POPCORN CEILING, LAMINATE FLOORS AND UNABLE TO VERIFY IF THE BASE CABINETS WERE NOT HOLLOW. PHYSICAL FACILITY ITEMS
WILL BE MONITORED AT FUTURE INSPECTIONS.

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 1021221174 of 06/13/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
JOY POPE
REGISTERED NURSE

Signed:_____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us