DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 17, 2022

Administrator
Millers Landing Senior Living
155 5th Avenue South
Minneapolis, MN 55401

RE: Project Number(s) SL34712015

Dear Administrator:

On March 2, 2022, the Minnesota Department of Health completed a follow-up evaluation of your agency to determine correction of orders found on the evaluation completed on March 2, 2022. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the March 2, 2022 evaluation.

In accordance with Minn. Stat. § 144A.474, Subd. 11, state licensing orders issued pursuant to the last evaluation completed on March 2, 2022, found not corrected at the time of the March 2, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1760-Documentation Of Administration Of Medication-144g.71 Subd. 8
1950-Administration Of Treatments And Therapy-144g.72 Subd. 4
1960-Documentation Of Administration Of Treatments-144g.72 Subd. 5

The details of the violations noted at the time of this follow-up evaluation completed on March 2, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up evaluation completed on March 2, 2022, we identified the following violation(s):

2320-Appropriate Care And Services-144g.91 Subd. 4

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144A.474, Subd. 8(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144A.475 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144A.474, Subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill at 651-201-3993 .

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your agency's Governing Body.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	R 03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL34712015 On February 28, through March 2, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 11, 2021. At the time of the survey, there were 35 residents; 34 receiving services under the Assisted Living/ Dementia Care license. As a result of the revisit, the following orders were reissued: 1790, 1950, 1960; the following new order was written: 2320. As a result of the revisit, the licensee is in substantial compliance.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care License providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 480}	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{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	{01760}		

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{01760}	Continued From page 2 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 medications were administered as prescribed for one of three residents (R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7 R7's melatonin (sleep enhancer) medication was not administered as prescribed. R7's diagnoses included diabetes and hypertension. R7's Service Plan dated December 14, 2021, indicated R7 received services, which included medication administration and assistance with blood glucose (sugar) monitoring procedures. R7's prescriber orders dated December 9, 2021, included an order for melatonin three (3) milligrams (mg) once every evening. R7's medication administration record (MAR) dated February 1, through February 27, 2022, indicated the prescribed melatonin medication was not administered 16 times (60%). The unlicensed personnel (ULP) who documented noted on multiple occassions the medication was	{01760}		

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{01760}	Continued From page 3 not available and was "Backorder." On March 1, 2022, at approximately 8:50 a.m., the surveyor observed ULP-L administer prescribed oral medications and subcutaneous insulin correctly. On March 2, 2022, at approximately 10:30 a.m. director of nursing (DON)-A confirmed R7 had not received the melatonin medication as prescribed. DON-A stated she was unaware R7 had not received the medication; and, the ULP were previously trained to notify her if a medication required re-ordering. The licensee's Medication and Treatment Orders - Implementing policy dated August 1, 2021, indicated "Upon receipt of a medication and or treatment order, whether new or change of an order from an authorized prescriber, a licensened nurse must take action to implement the order within 24 hours." No further information provided.	{01760}		
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health	{01950}		

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{01950}	Continued From page 4 professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, specific instructions for each resident and documented those instructions in the resident's record regarding receiving blood glucose monitoring for one of three residents (R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7's record "Medication Sheet" (intended as documentation of the delegated treatment task of blood glucose (sugar) results) dated February 1, 2022, through February 28, 2022, noted unlicensed personnel (ULP)-C assisted with the blood glucometer finger stick check procedures	{01950}		

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{01950}	Continued From page 5 on multiple occasions. R7's "Medication Passing Detail - Check Blood Sugar" document dated February 1, through February 28, 2022, indicated blood glucose monitoring results ranged from 64 milligrams/deciliter (mg/dl) to 427 mg/dl. R7's record did not contain any specific written instructions from a RN related to R7's blood glucose monitoring or when staff notify a nurse when R7's blood glucose results were outside parameters. On March 1, 2022, at approximately 8:45 a.m., ULP-L was observed assisting R7 with a blood glucose check which resulted in a reading of 247 mg/dl. Upon query, ULP- L stated she thought a low blood glucose level would be under 100 (mg/dl) and a high reading would be over 300 or 400 (mg/dl). ULP-L stated she would call the RN for blood glucose results under 100 or over 300. ULP-L confirmed there were no written procedures in R7's record instructing when to notify a nurse if an issue arose related to R7's elevated or low blood glucose result. On March 1, 2021, at approximately 12:00 p.m. director of nursing (DON)-A confirmed R7's treatment plan for blood glucose monitoring lacked any printed instructions or parameters, intended for the ULP to follow, of when to notify the nurse if a problem arose. The licensee's undated Treatment and Therapy Management policy noted the licensee's nurse was responsible for development of a resident's individual treatment or therapy service plan which should include procedures staff should follow	{01950}		

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{01950}	Continued From page 6 regarding when to notify a nurse if a problem arose. No further information was provided.	{01950}		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure each treatment or therapy was documented, and when not documented as prescribed, the provider must document the reason why and any follow-up procedures that were provided to meet the resident's needs for one of three residents (R7), who received treatments/therapies. 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	{01960}		

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{01960}	Continued From page 7 situation has occurred only occasionally). The findings include: R7's prescriber orders dated December 9, 2021, indicated to assist R7 with blood glucose (sugar) monitoring four times daily, before each meal and at bedtime. R7's record lacked documentation to consistently indicate R7's blood glucose monitoring was completed, as ordered. R7's record "Medication Sheet" (intended as documentation of the delegated treatment task of blood glucose (sugar) results) dated February 14, 2022, through February 22, 2022, lacked documentation to indicate assistance with blood glucose monitoring four times daily, was provided on eight out of 36 times (22%). On March 1, 2022, at approximately 8:45 a.m., unlicensed personnel (ULP)-L was observed assisting R7 with a blood glucose monitoring fingerstick procedure which resulted in a reading of 247 milligrams/deciliter (mg/dl). On March 1, 2021, director of nursing (DON)-A confirmed R7's record lacked documentation of their treatment administered as prescribed. DON-A stated R7's glucometer stopped operating correctly for the period of time specified above and the ULP were not able to complete the treatment as prescribed. DON-A stated the licensee had purchased a new, fully functioning blood glucose monitoring device for R7 and the situation had been resolved. The licensee's 7.22 Documenting Treatment and Therapy policy dated August 1, 2021, indicated	{01960}		

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{01960}	Continued From page 8 the resident record must include documentation of all services provided. No further information was provided.	{01960}		
02320 SS=D	144G.91 Subd. 4 Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain a clean and safe environment, as an assisted living service, and failed to ensure unlicensed personnel (ULP) were trained and competent to perform their duties. This affected one of four resident (R8). 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 March 1, 2022 at approximately 8:30 a.m. the director of nursing (DON)-A and surveyor entered R8's room, the following was observed: - The resident was lying on the bed fully clothed,	02320		

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02320	Continued From page 9 the mattress pad was visibly soiled. The pillow lacked a pillow case. - The sink in the kitchenette had dirty dishes dried with food. - The bathroom floor had a 14 inch soiled ring of dried urine and dried black particles resembling dried dirt was around the base of the toilet. The service plan dated and signed on January 6, 2022 confirmed R8 received daily services including, housekeeping, laundry, linen change and trash removal. On March 3, 2022, at 9:30 a.m. the licensed assisted living director (LALD)-B stated resident rooms should be cleaned regularly. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Electronically Delivered

January 11, 2022

Administrator
Millers Landing Senior Living
155 5th Avenue South
Minneapolis, MN 55401

RE: Project Number(s) SL34712015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 11, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

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

St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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.

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

§ 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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

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

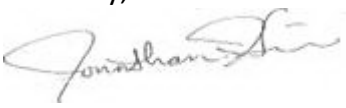
REQUESTING A HEARING

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

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

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

Sincerely,



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HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	12/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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: SL34712015 On December 7, 2021, through December 11, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 34 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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=D	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 staff responded promptly and effectively to individual resident emergencies for one of two residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee failed to ensure the licensee's staff responded to a resident's call light in a reasonable amount of time to ensure adequate care of the licensee's residents within accepted health care standards. R3's medical record indicated R3 moved into the licensee's establishment on November 3, 2021, due to diagnoses including obstructive sleep apnea, Parkinson's disease, and nervous system degeneration. R3's service plan dated November 3, 2021, indicated R3 received services from the licensee which included bathing assistance, toileting, dressing and grooming, medication checks, and transferring using two of the licensee's staff. R3's service plan also indicated R3 was wheelchair dependent and unable to walk. The licensee's call light reports indicated R3 pushed her call light pendant on the following dates and times: - November 27, 2021, at 8:31 a.m., R3 waited 25 minutes before the licensee's staff responded. - November 29, 2021, at 11:31 a.m., R3 waited 55 minutes before the licensee's staff responded. - November 29, 2021, at 3:54 p.m., R3 waited 28 minutes before the licensee's staff responded. - November 30, 2021, at 12:37 p.m., R3 waited 38 minutes before the licensee's staff responded.	0 470		

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0 470	Continued From page 3 - November 30, 2021, at 7:38 p.m., R3 waited 27 minutes before the licensee's staff responded. - December 2, 2021, at 12:58 p.m., R3 waited 50 minutes before the licensee's staff responded. - December 3, 2021, at 2:43 p.m., R3 waited 29 minutes before the licensee's staff responded. - December 4, 2021, at 11:21 p.m., R3 waited 40 minutes before the licensee's staff responded. - December 7, 2021, at 12:20 p.m., R3 waited 29 minutes before the licensee's staff responded. - December 8, 2021, at 9:11 a.m., R3 waited 31 minutes before the licensee's staff responded. - December 8, 2021, at 11:33 a.m., R3 waited 33 minutes before the licensee's staff responded. During an interview on December 7, 2021, at 9:30 a.m., R3 stated she uses a call pendant and sometimes the licensee's staff does not respond after R3 activates the pendant. R3 stated she often calls her family at home when staff does not respond to her call pendant. R3 also stated her family comes to the licensee's establishment and provides her cares. During an exit interview on December 9, 2021, at 3:00 p.m., licensed assisted living director (LALD)-B stated she did not know why R3's call lights were not being answered in a timely manner. LALD-B asked the surveyors if there was a set time call lights should be answered. The licensee's 24-Hour Emergency Response policy dated August 1, 2021, indicated the licensee's residents have access to 24-hour emergency response by staff. The policy also indicated when residents pressed their emergency response button, a designated staff person was notified on an emergency phone, and the staff person would answer the phone immediately.	0 470		

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0 470	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 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 comply with Minnesota Food Code, chapter 4626. This had the potential to affect all 34 residents residing at 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	0 480		

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0 480	Continued From page 5 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated December 9, 2021, for the specific Minnesota Food Code deficiencies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. This	0 510		

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0 510	Continued From page 6 deficient practice had the potential to affect all of the licensee's 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 of the residents). The findings include: Hand Hygiene and Maintenance of Medical Equipment Resident (R)5 resided within the secured dementia care unit. On December 8, 2021, at 8:10 a.m., unlicensed personnel (ULP)-E was observed providing a blood sugar finger stick check for R5. While standing at the medication cart in the main dining room and without any hand hygiene, ULP-E applied a pair of disposable gloves. ULP-E directed R5 back to his apartment, completed the finger stick blood sugar check on R5's third finger of his left hand, disposed of the used equipment in a bio-hazard container on his kitchen counter, removed her gloves and without hand hygiene applied a clean pair of gloves. ULP-E then followed R5 to his bathroom. A large over-night Foley (indwelling flexible tube passed through the urethra and into the bladder to drain urine) catheter bag was observed on the floor in front of the toilet without a protective tip on the end of the proximal length of tubing. The Foley catheter drainage bag was observed to have a small amount of urine remaining in the bottom. R5	0 510		

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0 510	Continued From page 7 stated the Foley catheter drainage bag had been on the floor for several days. Upon query, ULP-E stated it was the responsibility of the night shift ULP to change his large (night time) drainage bag to the smaller day time drainage leg bag. ULP-E stated the night drainage bag should be hung up in the shower and rinsed with water. ULP-E stated she never did anything with R5's large night urine drainage bag. ULP-E placed the night drainage bag onto a bar in R5's shower without rinsing or any maintenance of the medical device. ULP-E removed her disposable gloves and without hand hygiene, returned to the medication cart in the main dining room. On December 8, 2021, at 8:55 a.m., ULP-E was observed retrieving R5's Lantus (long acting insulin) flexpen (a disposable pre-filled pen-like device to inject insulin) from an unlocked medication refrigerator in an unlocked ULP break room. Without any hand hygiene, ULP-E put on a pair of disposable gloves, dialed up the prescribed insulin units, walked to R5 and administered R5's insulin in a more private enclave of the dining room. ULP-E disposed of the insulin syringe tip in a bio-hazard container, removed her disposable gloves, and then washed her hands. Upon query, while ULP-E was standing in front of the medication cart, ULP-E stated she was not sure where any hand sanitizer was, either on or in the medication cart. ULP-E searched the top drawer of the medication cart, found a small container of hand sanitizer, and stated she should have used it more often. ULP-E had not washed or sanitized her hands in between changing any of her disposable gloves. At 9:05 a.m., ULP-E confirmed she had not washed or sanitized her hands between changing her disposable gloves, before and after blood glucose monitoring, and after retrieving R5's	0 510		

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0 510	Continued From page 8 Foley catheter bag from the bathroom floor. On December 8, 2021, at approximately 10:10 a.m., registered nurse (RN)-C confirmed ULP-E should have sanitized her hands after removal of gloves and applying new gloves. RN-C stated she thought the ULP had all been previously trained on proper hand washing techniques during direct care resident activities. Hand Hygiene (HH) On December 8, 2021, at approximately 8:30 a.m., ULP-F was observed preparing medications for a resident. ULP-F touched each medication with her bare hands. ULP-F did not perform HH prior to or after administering medications to the resident. On December 8, 2021, at approximately 9:00 a.m., ULP-F prepared a glass of water and medications for another resident. ULP-F did not perform HH prior to or after administering the resident's medications. On December 8, 2021, at approximately 9:30 a.m., ULP-F prepared medications for a resident and touched each medication with her bare hands. ULP-F did not perform HH prior to or after administering the resident's medications. During an interview on December 8, 2021, at approximately 9:45 a.m., ULP-F did not recall being trained by the licensee about infection control measures. ULP-F stated the licensee provided hand sanitizer. ULP-F stated she sometimes forgot to sanitize her hands before and after assisting residents. The licensee's 6.22 Catheter Care policy dated	0 510		

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0 510	Continued From page 9 August 1, 2021, lacked any printed instructions related to infection control procedures or maintenance of a large Foley catheter drainage bag. The licensee's 8.07 Gloves policy, dated as above, noted after removal of disposable gloves an employee would wash their hands. The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated proper handwashing techniques would be used to protect the spread of infection. The policy also indicated handwashing would be completed before and after resident cares. The licensee's 8.14 Standard Precautions policy dated August 1, 2021, indicated the licensee ensured standard precautions would be used by the licensee's staff. The policy also indicated standard precautions included hand washing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=F	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	0 650		

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0 650	Continued From page 10 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 and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for four of four employees (registered nurse (RN)-A, RN-C, unlicensed personnel (ULP)-E, ULP-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 650		

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0 650	Continued From page 11 The findings include: RN-A RN-A's employee record lacked evidence of documentation of orientation to assisted living regulations. RN-A had a hire date of October 4, 2021, to provide management and oversight of direct care to the licensee's residents. On December 9, 2021 at approximately 2:30 p.m., licensed assisted living director (LALD)-B verified RN-A's record lacked evidence of orientation. RN-C RN-C's employee record lacked evidence of any orientation, a signed job description and tuberculosis (TB) baseline health screenings. RN-C had a hire date of March 1, 2021, to provide direct care to the licensee's residents as an RN. On December 8, 2021, from approximately 8:00 a.m. to 10:00 a.m., RN-C was observed intermittently performing nursing tasks and administering medications to the licensee's residents. On December 9, 2021, at approximately 2:30 p.m., LALD-B verified RN-C record lacked evidence of any orientation, a signed job description, and evidence of TB health screenings. ULP-E ULP-E's employee record lacked evidence of documentation of orientation to assisted living	0 650		

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0 650	Continued From page 12 regulations, a signed job description, and TB health screenings. ULP-E had a hire date of June 17, 2021, to provide direct care to the licensee's residents. On December 8, 2021, from approximately 8:00 a.m. to 10:00 a.m., ULP-E was observed providing direct care to the licensee's residents. On December 9, 2021, at approximately 2:30 p.m., LALD-B verified ULP-E record lacked evidence of orientation to assisted living regulations, a signed job description, and evidence of TB health screenings. ULP-F ULP-F's employee record lacked evidence of documentation of orientation to assisted living regulations, a signed job description, TB health screenings, and annual performance reviews. ULP-F had a hire date of October 25, 2020, to provide direct care to the licensee's residents. On December 8, 2021, from approximately 8:00 a.m. to 10:00 a.m., ULP-F was observed providing direct care to the licensee's residents. On December 9, 2021, at approximately 2:30 p.m., LALD-B verified ULP-F record lacked evidence of orientation, a signed job description, evidence of health screenings, and annual performance reviews. The licensee's 4.05 Employee Records policy dated August 1, 2021, indicated the licensee's employee records would include records of all training, a current signed job description, documentation of annual performance reviews,	0 650		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 650	Continued From page 13 verification of required health screenings, and verification of completed orientation and annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test)	0 660		

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0 660	Continued From page 14 were completed and documented for three of four employees (registered nurse (RN)-C, unlicensed personnel (ULP)-E, ULP-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-C RN-C was hired by the licensee on March 1, 2021, as a contractor, to provide direct care to the licensee's resident's as a RN. RN-C's employee records lacked evidence of baseline TB history and symptom screens or screenings for active TB with either a two-step TST or blood test. On December 8, 2021, from approximately 8:00 a.m. to 10:00 a.m., RN-C was observed performing tasks and administering medications to the licensee's residents. On December 9, 2021, at approximately 2:30 p.m., licensed assisted living director (LALD)-B verified RN-C's employee record lacked evidence of health screenings, including TB screenings. ULP-E ULP-E was hired by the licensee on June 17,	0 660		

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0 660	Continued From page 15 2021, to provide direct care to the licensee's residents. ULP-E's employee records lacked evidence of baseline TB history and symptom screens or screenings for active TB with either a two-step TST or blood test. On December 8, 2021, from approximately 8:00 a.m. to 10:00 a.m., ULP-E was observed providing direct care to the licensee's residents. On December 9, 2021 at approximately 2:30 p.m., LALD-B verified ULP-E's employee records lacked evidence of health screenings, including TB screenings. ULP-F ULP-F was hired by the licensee on October 25, 2020, to provide direct care to the licensee's residents. ULP-F's employee records lacked evidence of baseline TB history and symptom screens or screening for active TB with either a two-step TST or blood test. On December 8, 2021, from approximately 8:00 a.m. to 10:00 a.m., ULP-F was observed providing direct care to the licensee's residents. On December 9, 2021, at approximately 2:30 p.m., LALD-B verified ULP-F's employee record lacked evidence of health screenings, including TB screenings. The licensee's most current TB facility risk assessment dated October 1, 2021, noted a low risk.	0 660		

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0 660	Continued From page 16 The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated the licensee would establish and maintain a comprehensive TB infection control program. The policy also indicated the licensee would screen employees upon hire for active signs of TB using the baseline TB screening tool, and have a blood test or a two-step Mantoux documented on the screening tool. The policy also indicated staff screening results would be kept in each employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
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 provide and maintain the building physical environment, including walls, floors, and ceiling, in a continuous state of good repair and operation for health, comfort, and well-being of residents in accordance with a maintenance and repair program. This had the potential to affect all residents of the facility and staff.	0 800		

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0 800	Continued From page 17 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 9, 2021, during a facility tour between 10:45 a.m. and 12:30 p.m. with environmental lead (EL)-G, the following was observed: 1. Activity room A had stained ceiling tiles in the middle of the ceiling. Stained ceiling tiles can be an indication of a leak in the plenum space. EL-G confirmed the tiles were stained and stated she would replace them. 2. Activity room storage closet did not have cover plate on light switch. EL-G acknowledged missing cover plate and stated she would install one as soon as possible. 3. Fourth floor dining room closet was missing wall base. EL-G acknowledged missing wall base and stated she would get new wall base installed. Fourth floor is currently vacant. 4. First floor kitchen storage room had multiple ceiling tiles that were severely stained, sagging, or broken. Dry foods were being stored in this closet. Stained, sagging, and damaged ceiling tiles can be an indication of a leak in the plenum space. EL-G acknowledged tiles were in need of replacement.	0 800		

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0 800	Continued From page 18 The licensee lacked documentation for a maintenance plan or schedule for repairs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
01350 SS=D	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the licensee for one of one (registered nurse (RN)-C) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-C was the only staff person contracted on March 1, 2021, to provide nursing services to the licensee's residents. RN-C's employee record lacked evidence of the following required content	01350		

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01350	Continued From page 19	01350		

of orientation to assisted living:
- Overview of assisted living statutes;
- Review of the provider's policies and procedures;
- Assisted living bill of rights;
- Handing of resident complaints, reporting of complaints, and where to report; and
- Principles of person-centered planning and service delivery.

RN-C's employee record also lacked evidence of receiving eight hours of dementia related training to include the following required content:
- An explanation of Alzheimer's disease and other dementias;
- Assistance with activities of daily living;
- Problem solving with challenging behaviors;
- Communication skills; and
- Person-centered planning and service delivery

On December 8, 2021, at 9:50 a.m. RN-C confirmed she was contracted to work for the licensee through a supplemental staffing agency, Lakeland Staffing, in mid-July 2021. RN-C stated she was oriented by the licensee's previous RN director to primarily resident care service delivery expectations. RN-C stated she thought she was minimally oriented to their policies and procedures, but was unaware of the licensee's current license type, received no training on an assisted living facility's current required statutes, received no training on the licensee's complaint process, nor had she completed any on-line training through the licensee's Educare (online learning service which provides unlimited access to a range of certified training courses used by home care providers) software program.

On December 9, 2021, at approximately 2:30

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01350	Continued From page 20 p.m., licensed assisted living director (LALD)-B verified RN-C's employee record lacked the required orientation, training, and competencies. The licensee's 5.01 Orientation of Staff and Supervisors policy dated August 1, 2021, indicated all licensee's staff providing direct services to residents will complete an orientation to assisted living licensing requirements and regulations prior to providing services to the licensee's residents. The licensee's 5.03 Dementia Training policy dated August 1, 2021, indicated all licensee's staff completed dementia training at the time of hire. The policy also indicated the licensee's employees completed eight hours of initial dementia training within 80 hours of the employees start date. The licensee's 5.10 Training Records policy dated August 1, 2021, indicated the licensee would maintain a record of required staff training and competencies for the licensee's staff. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	01350		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 21 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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01470	Continued From page 22 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living facility statutes included all the required content for three of three employees (registered nurse (RN)-C, unlicensed personnel (ULP)-E, ULP-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-C RN-C was contracted on March 1, 2021, to provide nursing services to the licensee's residents. RN-C's employee record lacked evidence of the following required content of orientation to assisted living: - Overview of assisted living statutes; - Review of the provider's policies and	01470		

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01470	Continued From page 23 procedures; - Assisted living bill of rights; - Handing of resident complaints, reporting of complaints, and where to report; and - Principles of person-centered planning and service delivery. ULP-E ULP-E was hired on June 17, 2021, to provide direct care to the licensee's residents. ULP-E's employee record lacked evidence of the following required content of orientation to assisted living: - Overview of assisted living statutes; - Review of the provider's policies and procedures; - Assisted living bill of rights; - Handing of resident complaints, reporting of complaints, and where to report; and - Principles of person-centered planning and service delivery. ULP-F ULP was hired on October 25, 2020, to provide direct care to the licensee's residents. ULP-F's employee record lacked evidence of the following required content of orientation to assisted living: - Overview of assisted living statutes; - Review of the provider's policies and procedures; - Assisted living bill of rights; - Handing of resident complaints, reporting of complaints, and where to report; and - Principles of person-centered planning and service delivery. On December 9, 2021, at approximately 2:30	01470		

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01470	Continued From page 24 p.m., licensed assisted living director (LALD)-B verified RN-C's, ULP-E's, and ULP-F's employee records lacked the required orientation. The licensee's 5.01 Orientation of Staff and Supervisors policy dated August 1, 2021, indicated all licensee's staff providing direct services to residents, completed an orientation to assisted living licensing requirements and regulations prior to providing services to the licensee's residents. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	01470		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor	01500		

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01500	Continued From page 25 blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01500		

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01500	Continued From page 26 licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-F) with training records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F's employee record lacked evidence of at least eight hours of annual training for each 12 months of employment in the required topics. ULP-F had a hire date of October 25, 2020, to provide direct care to the licensee's residents. On December 8, 2021, from approximately 8:00 a.m. to 10:00 a.m., ULP-F was observed providing direct care to the licensee's residents. On December 9, 2021 at approximately 2:30 p.m., licensed assisted living director (LALD)-B verified ULP-F's employee record lacked evidence of eight hours of annual training. The licensee lacked appropriate annual training policies related to the new Assisted Living Facility statutes enacted August 1, 2021. No further information was provided.	01500		

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01500	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=F	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted 90 day assessments for one of two residents (R1) as required with records reviewed.	01620		

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MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

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01620	Continued From page 28 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's record lacked evidence of a required RN assessment within 90 days from the previous nurse assessment. R1 was admitted on July 1, 2019, with diagnoses of diabetes, peripheral vascular disease and dementia. R1's 90 Day Assessment form dated November 4, 2021, indicated R1 ambulated with an assisted device and required assistance with daily personal hygiene, dressing and grooming, bathing, medication administration, laundry and housekeeping services. The RN assessment lacked evidence of R1's status related to current treatments for diabetes management or application of TED (thrombo-embolism deterrent hose; used in the treatment of edema) stockings daily for peripheral vascular disease. R1's record noted a 90 Day Assessment completed on November 4, 2021, assessment (96 days from the provider's conversion to an assisted living license on August 1, 2021). On December 9, 2021, at approximately 11:30 a.m., licensed assisted living director (LALD)-B stated she was aware of the requirement for a minimum of 90 day RN assessments from the	01620		

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01620	Continued From page 29 nurse's last resident assessment. LALD-B verified R1's record lacked evidence of a 90 day monitoring reassessment following the residents' prior nurse assessment. LALD-B stated she was unsure if the remainder of the licensee's residents would have evidence of 90 day RN assessments from the date of their last assessment, as required, in their records. LALD-B stated Director of Nursing (DON)-A was aware of the requirement and was currently working to ensure all of the licensee's residents were on a schedule for required 90 day nurse assessments from the date of the last assessment. The licensee's 6.01 Assessment, Reviews and Monitoring policy noted the RN was responsible to complete a monitoring assessment a minimum of every 90 days from the previous assessment for each resident who received assisted living level services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and	01750		

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01750	Continued From page 30 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP)-E, demonstrated competency for administering subcutaneous insulin to a resident (R)5. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R5's prescribed insulin was administered incorrectly, without initially priming the flexpen, according to manufacturer's recommendations. R5 had diagnoses to include diabetes and dementia. R5's prescriber orders dated December 6, 2021, not all inclusive indicated Lantus insulin (long-acting) 100 units/ml (milliliter) flexpen (a disposable pre-filled pen-like device to inject insulin) 25 units twice daily before breakfast and evening meals; and additional sliding scale insulin of two units to be given, if pre-meal blood sugar was greater than 200 mg/dl (milligrams per deciliter) three times daily before meals. On December 8, 2021, at 8:35 a.m., unlicensed	01750		

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01750	Continued From page 31	01750		

personnel (ULP)-E was observed to assist R5 with a blood sugar (BS) check that resulted in a reading of 446 mg/dl, using an Accucheck glucometer device (a blood sugar (BS) monitoring device.) ULP-E called the registered nurse (RN)-C to notify her of the elevated BS result. ULP-E was instructed to increase the prescribed dose by two additional units. ULP-E visually checked the December, 2021, electronic medication administration record (MAR) for the written instructions, retrieved client R5's Lantus Solostar insulin flexpen from the medication refrigerator and dialed the flexpen to 27 units, then subcutaneously (SQ) administered R5's insulin into the right upper quadrant of his abdomen. The insulin flexpen had not been primed (withdraw and release two units to remove any air in the tip of the device) before administration. Upon query, ULP-E stated she was unaware the insulin flexpen should have been primed with two units prior to dialing up the prescribed dose of insulin and administration. ULP-E confirmed the MAR lacked any written instructions regarding priming the insulin flexpen prior to administration. ULP-E stated she did not remember being previously trained by an RN on priming an insulin flexpen prior to administration. ULP-E stated she had previously demonstrated competency by the RN (registered nurse) prior to SQ insulin administration.

R5's December 2021 MAR lacked evidence of any written instructions related to required two unit priming of the Lantus insulin flexpen prior to medication administration.

On December 8, 2021, at approximately 10:25 a.m., RN-C confirmed R5's MAR lacked written instructions related to the necessity of priming the insulin flexpen with two units prior to

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01750	Continued From page 32 administration of the insulin. RN-C confirmed the priming written instructions would not be in any of the licensee's resident MARs, with prescribed insulin administration, as she was not aware of that level of detail required in the MAR. RN-C verified she was unsure if all of the licensee's ULP who administered insulin via a flexpen had been trained in the correct procedures for priming the flexpen prior to administration of prescribed insulin. The licensee's 7.36 Insulin policy dated August 1, 2021, noted the RN would train and ensure the ULP demonstrated competency prior to administration of insulin. The policy lacked any instructions related to the required priming of an insulin flexpen with two units prior to administration of prescribed units of insulin. The manufacturer's recommendations for Lantus Solostar insulin flexpen administration dated December 2020, indicated the device needed to be primed with two units prior to each administration of prescribed insulin injections. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01750		
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	01760		

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01760	Continued From page 33 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 medications were administered according to manufacturer's instructions for one of one resident (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5's Lantus insulin was not administered per manufacturer's instructions. R5 had diagnoses to include diabetes and dementia. R5's Service Plan dated July 7, 2020, indicated the resident received medication management services to include medication administration. R5's Medication Treatment Assessment dated	01760		

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01760	Continued From page 34 July 27, 2021, noted R5 had memory impairments and forgetfulness and required assistance to administer insulin injections twice a day. R5's prescriber orders dated December 6, 2021, not all inclusive indicated Lantus insulin (long-acting) 100 units/ml (milliliter) flexpen (a disposable pre-filled pen-like device to inject insulin) 25 units twice daily before breakfast and evening meals; and additional sliding scale insulin of two units to be given, if pre-meal blood sugar was greater than 200 mg/dl (milligrams per deciliter) three times daily before meals. On December 8, 2021, at 8:35 a.m., unlicensed personnel (ULP)-E was observed to assist R5 with a blood sugar (BS) check that resulted in a reading of 446 mg/dl, using an Accucheck glucometer device (a blood sugar (BS) monitoring device.) ULP-E called the registered nurse (RN)-C to notify her of the elevated BS result. ULP-E was instructed to increase the prescribed dose by two additional units. ULP-E visually checked the December, 2021, electronic medication administration record (MAR) for the written instructions, retrieved client R5's Lantus Solostar insulin flexpen from the medication refrigerator and dialed the flexpen to 27 units, then subcutaneously (SQ) administered R5's insulin into the right upper quadrant of his abdomen. The insulin flexpen had not been primed (withdraw and release two units to remove any air in the tip of the device) before administration. Upon query, ULP-E stated she was unaware the insulin flexpen should have been primed with two units prior to dialing up the prescribed dose of insulin and administration. ULP-E confirmed the MAR lacked any written instructions regarding priming the insulin flexpen	01760		

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01760	Continued From page 35	01760		

prior to administration. ULP-E stated she did not remember being previously trained by an RN on priming an insulin flexpen prior to administration. ULP-E stated she had previously demonstrated competency by the RN (registered nurse) prior to SQ insulin administration.

On December 8, 2021, at approximately 10:25 a.m., RN-C confirmed the ULP-E should have ensured the insulin flexpen had been primed for two units prior to dialing up the prescribed dose of insulin, according to manufacturer's instructions. RN-C verified she was unaware if any of the other ULP assigned the delegated task of flexpen insulin administration for R5 were administering the prescribed insulin correctly.

R5's MAR lacked written instructions related to the necessity of priming the insulin flexpen with two units prior to administration of the insulin. RN-C confirmed the priming written instructions would not be in any of the licensee's resident MARs, with prescribed insulin administration, as she was not aware of that level of detail required in the MAR.

The licensee's 7.36 Insulin policy dated August 1, 2021, noted insulin medications must be administered according to the prescriber's orders. The policy lacked any instructions related to the required priming of an insulin flexpen with two units prior to administration of prescribed units of insulin.

The manufacturer's recommendations for use of a Lantus Solostar insulin flexpen administration dated December 2020, indicated the device needed to be primed with two units of insulin,

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01760	Continued From page 36 prior to dialing the prescribed dosage of each insulin injection. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were stored according to the manufacturer's directions for one of one resident's (R5) insulin and one of one medication refrigerator. In addition, the licensee's staff failed to ensure medications are securely locked and permitted only staff access. The findings include: The licensee's fifth floor medication storage refrigerator temperatures were not monitored and documented daily to ensure adequate storage of insulin medications. The medication refrigerator was not locked to ensure only staff access. The licensee's Vaccine Storage Temperature Log (Fahrenheit) record of the medication refrigerator temperatures dated November 2021 had been	01880		

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monitored daily only 15 times out of 30 days, with all temperatures noted in the normal range of 46 to 36 degrees (F).
The licensee's Vaccine Storage Temperature Log (Fahrenheit) record dated December 2021 noted the medication refrigerator temperatures had been only monitored on December 1, 2, 5, and 6, 2021. The medication refrigerator temperatures had not been recorded daily on the form for December 3, 4, or 7, 2021.

On December 8, 2021, at approximately 9:30 a.m., the fifth floor medication refrigerator located in the unlocked unlicensed personnel (ULP) staff office was observed with ULP-E. ULP-E confirmed the medication refrigerator was not locked. ULP-E verified the current temperature of the refrigerator was 38 degrees Fahrenheit (F). ULP-E stated the refrigerator temperatures were supposed to be monitored daily and recorded on licensee's Vaccine Storage Temperature Log (Fahrenheit) record dated December 2021. ULP-E verified the medication refrigerator temperatures had not been recorded daily on the form for December 3, 4, or 7, 2021.

The refrigerator contained the following medications for R5:
- two (2) opened, undated Lantus 100 units/ml insulin (a multiple dose pen shaped injector device for insulin administration) pens
- one (1) opened, undated, empty Lantus 100 units/ml insulin pens
- six (6) unopened Lantus 100 units/ml insulin pens
- one (1) opened, undated semaglutide (promotes insulin) 4.0 milligrams/3.0 ml pens

On December 8, 2021, at approximately 11:00 a.m., registered nurse (RN)-C confirmed the

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medication storage refrigerator was not locked nor secured to ensure only designated staff had access. RN-C confirmed the ULP staff office was not generally locked, nor was the medication refrigerator locked within the ULP break room. RN-C also verified the medications in the medication refrigerator were unsecured. RN-C provided the medication refrigerator temperature log dated November 2021. RN-C confirmed the licensee's staff had not complied with the procedure to monitor and document the medication refrigerator temperatures daily to ensure safe storage. RN-C stated she was unaware if it was her responsibility to monitor if the daily refrigerator temperatures were monitored and documented.

The manufacturer's instructions for Lantus insulin pens dated December 2020 indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F. Do not freeze. In addition, the instructions noted opened insulin pens could be used for up to 28 dates and then should be discarded.

The manufacturer's instructions for semaglutide insulin pens dated May 2021 indicated unopened pens should be stored in the refrigerator between 36 to 46 degrees F; and opened pens may be stored at room temperatures for 56 days. Do not allow to freeze.

The licensee's 7.11 Medication Storage policy dated August 1, 2021, noted medications would be securely locked and stored according to manufacturer's guidelines, refrigerated, room temperature or frozen. The policy lacked any language specific to storage of insulin, or medication refrigerator temperatures to be maintained between 36-46 degrees Fahrenheit.

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01880	Continued From page 39 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained, including the expiration date for time sensitive medications, for one of one resident (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's fifth floor medication refrigerator contained undated opened insulin flexpens of R5. On December 8, 2021, at approximately 9:30 a.m., the medication refrigerator located in the	01890		

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01890	Continued From page 40 unlocked unlicensed personnel (ULP) staff office was observed with ULP-E. The refrigerator contained the following medications for R5: - two (2) opened, undated Lantus 100 units/ml insulin (a multiple dose pen shaped injector device for insulin administration) pens - one (1) opened, undated, empty Lantus 100 units/ml insulin pens - one (1) opened, undated semaglutide (promotes insulin) 4.0 milligrams/3.0 ml pens - six (6) unopened Lantus 100 units/ml insulin pens On December 8, 2021, at approximately 11:00 a.m., registered nurse (RN)-C verified all of R5's opened insulin pens should have had a sticker on them to indicate the date opened by the ULP. RN-C stated she was aware opened Lantus and semaglutide insulin pens were available for use for a total of 28 days only, and could be stored at room temperature; however, the ULP staff stored them in the refrigerator. RN-C stated the licensee's staff had been taught to date any opened insulin pens by use of the stickers. RN-C confirmed the licensee's staff had not complied with the procedure to date opened insulin pens, with the date they were opened and when they expired. The manufacturer's instructions for Lantus insulin pens dated December 2020 indicated opened insulin pens could be used for up to 28 dates from the date opened and then should be discarded.	01890		

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01890	Continued From page 41 The manufacturer's instructions for semaglutide insulin pens dated May 2021 indicated opened insulin pens could be used for up to 28 dates from the date opened and then should be discarded. The licensee's 7.11 Medication Storage policy dated August 1, 2021, noted medications would be stored according to manufacturer's guidelines, refrigerated, room temperature or frozen. The policy lacked any language specific to dating refrigerated medications on the date opened and following guidelines related to the expiration or beyond-use date of a time sensitive dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name,	01910		

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01910	Continued From page 42 strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record for disposition of medications to include prescription numbers, as applicable, for one of one discharged resident (R4) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The findings include: R4's service plan dated March 18, 2020, indicated R4 received medication management services. R4 was discharged from the licensee's establishment on October 15, 2021. R4's medical record included a discharge summary dated October 15, 2021, which indicated R4 was discharged from the licensee's establishment due to R4's need for a higher level of care. R4's medical record included a record of the inventory and destruction of controlled and	01910		

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01910	Continued From page 43 uncontrolled substances. R4's disposition of medications lacked evidence of required individual prescription numbers documentation. On December 9, 2021, at approximately 2:30 p.m., licensed assisted living director (LALD)-B and registered nurse (RN)-A verified R4's discharge records lacked the required prescription numbers. The licensee's 7.23 Medication Disposal policy, dated August 1, 2021, indicated the licensee would dispose of any medications remaining upon the termination of the resident's service contract. The policy also indicated the licensee would document in the resident's record, the disposition of the medication to include the medication's name, prescription number as applicable, quantity, and to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment	01950		

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01950	Continued From page 44 or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. 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) instructed and verified competency with the proper methods to perform catheter bag maintenance prior to delegating the nursing task for two of two unlicensed personnel (ULP)-E and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R5's "Service Plan Agreement" document noted instructions dated November 22, 2021, for the evening and day ULP staff, not all inclusive, "Clean the leg bag by washing soapy warm water through the tubing. Splash the water around inside of the bag to rinse out the bag." The	01950		

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01950	Continued From page 45 instructions lacked any specific procedures related to maintenance of R5's larger night urine drainage bag. Another written instruction "Catheter Empty Bag" dated December 3, 2021, on the document above noted "NOC [night] RA [resident assistant/ULP] to check catheter bag during middle of shift and empty if needed until resident gets new large catheter bags delivered from Home Health." On December 8, 2021, at approximately 8:25 a.m., ULP-E was observed assisting R5 with personal hygiene to include assistance to his bathroom to empty a Foley catheter (indwelling flexible tube passed through the urethra and into the bladder to drain urine) leg bag into the toilet. A large urine drainage bag and extension catheter without a protective tip on the proximal end was observed on the bathroom floor in front of the toilet. The urine drainage bag contained a small amount of dark yellow colored urine. ULP-E stated the large urine drainage bag was supposed to be hanging in the shower stall and thought maybe it was supposed to be rinsed out with water. ULP-E confirmed there were no cleaning supplies available in R5's bathroom to assist with maintenance of the cleaning procedure. ULP-E stated it was the responsibility of the night shift to manage the night time large urine drainage bag, and she was not responsible to cleanse the equipment. On December 8, 2021, at approximately 8:35 a.m., ULP-E confirmed there were written procedures in R5's electronic medical record related to maintenance and cleaning of the catheter leg and night drainage bags for the ULPs on both the day and evening shifts. Instructions for the night shift ULP indicated they were suppose to ensure the urinary drainage bag was	01950		

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01950	Continued From page 46 emptied, as needed. On December 9, 2021, at approximately 8:45 a.m., ULP-F was observed assisting R5 with personal hygiene. R5 was lying on his left side in bed with the smaller Foley catheter leg bag attached to his left upper thigh. The catheter leg bag was disconnected from the Foley catheter, and R5's underwear and two disposable pads on the bed were noted to be wet with urine. ULP-F stated she was unaware how to reconnect the Foley catheter to the smaller leg drainage bag, and she would call the registered nurse (RN). ULP-F verified there were written procedures in R5's record how to clean the urine drainage bag; however, she did not think it was the responsibility of the ULP day shift. ULP-F also stated she did not remember being trained on maintenance of a Foley catheter. The larger night bag, still containing remaining urine from the previous day, was observed to be still hanging in R5's shower. On December 9, 2021, at 9:00 a.m., RN-C stated R5's night Foley drainage bag connector to the Foley catheter no longer fit, and the alternate home care provider had been notified about two weeks ago. RN-C stated all ULP shifts were instructed to more frequently check R5's leg drainage bag and empty it. RN-C also stated sometimes R5 would fiddle with the catheter, which sometimes disconnected his leg drainage bag from the catheter at night. RN-C confirmed ULP-E and ULP-F may not have been instructed in the proper methods or demonstrated the ability to competently follow procedures for maintenance of R5's Foley catheter. RN-C stated she was unsure of the competency status of other ULP who would be providing catheter maintenance tasks for R5.	01950		

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01950	Continued From page 47 The licensee's 6.14 Delegation of Assisted Living Service policy dated August 1, 2021, noted the licensee's RN was responsible to ensure the ULP had been trained and demonstrated competency prior to provision of the delegated task for any resident. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatments were performed as ordered for two of two residents (R1, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01960		

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01960	Continued From page 48 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are The findings include: R1 R1's prescriber orders dated August 11, 2021, indicated to assist R1 with the application of TED (thromboembolism deterrent hose; used in the treatment of edema) stockings in the morning and removal in the evening. R1's record lacked documentation to consistently indicate R1's TED stockings were applied and removed, as ordered. R1's "Service Delivery Record" document dated November 2021 lacked documentation to indicate assistance with application of the TED in the morning and removal at night, twice daily, had been provided on 19 out of 60 times (32%). R1's "Service Delivery Record" dated November 2021 did not indicate R1 received assistance with TED stocking application in the morning and removal at night, twice daily, 19 out of 60 times (32%). R1's "Service Delivery Record" dated December 1 through December 6, 2021, did not indicate R1 received assistance with TED stocking application in the morning and removal at night, twice daily, five out of 12 times (42%). On December 8, 2021, at approximately 8:00 a.m., unlicensed personnel (ULP)-E was observed giving verbal reminders and assisting R1 with application of TED stockings on both legs. ULP-E stated sometimes R1 was able to apply the TED stockings herself; however, she required daily reminders for application and some assistance in the evenings to remove them.	01960		

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01960	Continued From page 49 R5 R5's prescriber orders dated December 17, 2020, indicated staff were supposed to assist R5 with Foley catheter (indwelling flexible tube passed through the urethra and into the bladder to drain urine) cares related to a neuromuscular dysfunction of the bladder. R5's record lacked documentation to indicate R5 received assistance with Foley catheter cares, as ordered. R5's "Service Received" document dated December 2 through December 8, 2021, did not indicated R5 received assistance with change and maintenance of the catheter bags (night and leg) four out of 14 times (29%). R5's ULP service delivery documentation for change and maintenance with catheter cares was not provided for November 2021 as requested. On December 8, 2021, at approximately 8:35 a.m., ULP-E was observed assisting R5 with personal hygiene and with Foley catheter care of a small drainage leg bag. ULP-E stated sometimes R5 was able to empty the urine drainage himself. ULP-E stated R5 often times required daily reminders to empty his leg drainage bag, and the other ULP would assist him as needed. ULP-E confirmed the staff would document completion of an assigned delegated task in the resident's electronic record on a daily basis. On December 9, 2021, licensed assisted living director (LALD)-B confirmed R1 and R5's records lacked documentation of their treatments as indicated above.	01960		

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01960	Continued From page 50 The licensee's 7.22 Documenting Treatment and Therapy policy dated August 1, 2021, indicated the resident record must include documentation of all services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for treatment of application of TED stockings for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01970		

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01970	Continued From page 51 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's record lacked evidence of a current prescriber order for assistance with application of bilateral TED (thromboembolism deterrent hose; used in the treatment of edema) stockings. R1's record noted a prescriber order dated August 11, 2020, for assistance with TED stockings twice daily. R1's diagnosis included, but was not limited to, dementia, peripheral vascular disease, and diabetes. R1's service plan dated October 25, 2021, indicated R1 received services which included medication administration, bathing, transferring, dressing, grooming/hygiene, toileting, behavior management, TED stocking application, housekeeping and laundry. R1's "Service Delivery Record" indicated treatment services were inconsistently from November 1, 2021, through December 6, 2021, by the licensee's unlicensed personnel (ULP). R1's record lacked a current prescriber's orders for assistance with application and removal of TED stockings daily. On December 7, 2021, at approximately 10:10 a.m. during the entrance conference, Director of Nursing (DON)-A confirmed the licensee provided treatment and therapy services to several of the licensee's current residents who received assisted living services..	01970		

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01970	Continued From page 52 On December 8, 2021, at approximately 8:10 a.m., ULP-E was observed providing R1 with assistance with application of TED stockings during personal hygiene care in R1's bathroom. On December 9, 2021, at 11:20 a.m., DON-A provided a prescriber order for R1's TED stockings, dated as above. DON-A stated she would search for a more current prescriber order and provide it if found. DON-A stated she was aware a resident's prescribed treatment orders needed to be renewed at least annually. The licensee's 7.18 Medication and Treatment Orders - Renewal policy dated August 1, 2021, indicated the RN was responsible for maintaining current prescriber orders for all resident medication, treatments and therapies provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.	02040		

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02040	Continued From page 53 This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide the proper documentation that a hazard vulnerability or safety risk assessment was performed on and around the property. This has the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 9, 2021, at approximately 12:30 p.m. while reviewing records, the licensee provided no evidence of a completed hazard vulnerability assessment for the facility. On December 9, 2021, at approximately 12:40 p.m., the licensed assisted living director (LALD)-B confirmed the facility had not yet fully developed the required hazard vulnerability assessment. Global issues, such as fire, gas leak, epidemic, and shooter had been identified, but mitigation procedures were not yet developed. LALD-B further indicated local hazards that are site, building, and population specific were also not developed. No further information was provided.	02040		

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02040	Continued From page 54 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week who where responsible for responding to requests of residents for assistance in the secured dementia care unit. This resulted in an immediate correction order issued on December 10, 2021. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee holds an Assisted Living with	02070		

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MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

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02070	Continued From page 55 Dementia Care license for a bed capacity of 55 residents. The licensee failed to ensure one or more staff were always available during the night shift in each of the two secured dementia care units within the building. On December 7, 2021, at approximately 11:15 a.m. during the initial tour of the facility with licensed assisted living director (LALD)-B, it was observed the facility consisted of 22 residents with assisted living services on their 2nd, 3rd, and 7th residential floors. The facility also had five residents residing in the 6th floor secured dementia care unit, and seven residents in the 5th floor secured dementia care residential floor. The licensee had a total of 12 residents residing in the two dementia care units. The current total census at the facility was 34 residents who received assisted living services. On December 7, 2021, at 1:17 p.m. LALD-B provided a copy of the licensee's posted staffing plan and a more detailed "PowerScheduler Printout" that noted only two unlicensed personnel (ULP) were regularly scheduled for the night shift, 10:00 p.m. through 6:30 a.m. for all 34 assisted living residents. LALD-B confirmed the two scheduled ULP staff were individually each assigned to one of the two secured dementia care units. LALD-B stated if an assisted living services resident on one of the other residential floors used their call pendant at night, one of the two ULP in the dementia care unit would check to ensure the dementia care residents were asleep on the designated unit. If all of the dementia care residents were asleep, then the ULP would leave the unit and answer the call pendant of the assisted living services resident on another floor.	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	12/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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
02070	Continued From page 56 The ULP who had left their assigned dementia care unit would then notify, by their walkie talkie, the second ULP assigned on the other dementia care unit. On December 9, 2021, at approximately 9:15 a.m. ULP-F confirmed she previously intermittently worked the night shifts, and the regular staffing pattern was to have one ULP in each secured dementia care unit, for a total of two staff for the entire facility. ULP-F stated if another assisted living services resident used their call pendant and needed assistance on the night shift, the ULP would check if all dementia care unit residents were sleeping, then they would leave their unit unattended to assist a resident on another floor (2nd, 3rd, or 7th floor.) ULP-E verified she could be gone for up to maybe 10 minutes to assist another resident. ULP-F stated this was the licensee's current procedure for night shift assistance of the assisted living services residents residing on the other floors. On December 10, 2021, at 12:17 p.m. RN-C stated she was aware there were only two ULP assigned for the facility's night shifts with the intention of one ULP for each secured dementia care unit. RN-C stated she was unaware of the procedure for how the remaining assisted living with services residents call pendants would be answered. On December 10, 2021, at 12:23 p.m. ULP-J confirmed she regularly worked the night shift on the 6th floor dementia care secured unit. ULP-J verified when an assisted living (AL) services resident used their call pendant requesting assistance, she would check and confirm all her assigned dementia care residents were asleep,	02070		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	12/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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
02070	Continued From page 57 call the alternate ULP (5th floor dementia care unit)to notify him, then leave the dementia unit unattended to assist another AL resident. ULP-J stated she would be gone from her designated dementia care unit, generally 10 to 15 minutes. If the assistance took longer than approximately 10 minutes, she stated she would call the alternate ULP, request them to leave their designated dementia care unit unattended (if the residents were all sleeping), and go to ULP-J's unit to check on residents. The licensee's 2.01 24-Hour Emergency Response policy dated August 1, 2021, noted a designated staff person would carry an emergency phone at all times to be answered immediately. The policy lacked any language to address the requirement of an establishment of one or more persons to be physically present and available 24 hours a day, seven days a week, who where responsible for responding to requests of residents for assistance in the secured dementia care unit. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On December 12, 2021, this order was corrected as confirmed by document review/email conversation between licensee and engineering personnel and evaluation supervisor on December 12, 2021.	02070		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	12/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLERS LANDING SENIOR LIVING	155 5TH AVENUE SOUTH MINNEAPOLIS, MN 55401

(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 58 devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice with statutory language to disclose electronic monitoring activity was posted at the main entry of the facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 7, 2021, at 11:40 a.m., the main entry way of the establishment was observed with an Electronic Monitoring Requirement in Minnesota signage dated August 2021 to notify visitors of electronic monitoring. The signage lacked the required statutory language, "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." On December 7, 2021, at 11:45 a.m., licensed assisted living director (LALD)-B confirmed the	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34712	A. BUILDING: _____ B. WING _____	12/11/2021

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03090	Continued From page 59 common areas of the facility on the main floor had video cameras. LALD-B stated residents were notified of the cameras on admission, and cameras were not present in resident rooms. LALD-B confirmed the licensee's electronic monitoring signage posted at the main entry way of the facility lacked the required language; she stated she was unaware of the specificity of the requirement. The licensee's 2.15 Electronic Monitoring policy dated August 1, 2021, noted signs would be installed at each facility entrance accessible to visitors that stated, "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 and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *12/09/21*
Time: 13:17:49
Report: 7963211164

Food and Beverage Establishment Inspection Report

Location:
Millers Landing Senior Living
155 5th Avenue South
Minneapolis, MN55401
Hennepin County, 27

Establishment Info:
ID #: 0037649
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522144255
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.

ESTABLISHMENT DOES NOT HAVE A CURRENT EMPLOYEE ILLNESS LOG ON SITE. BLANK LOG AND FACT SHEET EMAILED TO FACILITY.

Comply By: 12/09/21

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

KATIE STADTHER (LALD) HAS CERTIFICATE FOR A COMPLETED SERVE SAFE TRAINING BUT DOES NOT HAVE A STATE OF MINNESOTA CERTIFIED FOOD MANAGER CERTIFICATE. APPLICATION AND FACT SHEETS EMAILED TO FACILITY.

Comply By: 12/09/21

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

Acid: = .55OZ/GA at Degrees Fahrenheit
Location: L
Violation Issued: No

Type: Full
Date: *12/09/21*
Time: 13:17:49
Report: 7963211164
Millers Landing Senior Living

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: DELI TURKEY
Temperature: 35 Degrees Fahrenheit - Location: 2 DOOR COOLER
Violation Issued: No

Process/Item: TZATZIKI SAUCE
Temperature: 36 Degrees Fahrenheit - Location: 2 DOOR COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 35 Degrees Fahrenheit - Location: 2 DOOR GLASS COOLER
Violation Issued: No

Process/Item: POTATOES
Temperature: 203 Degrees Fahrenheit - Location: COOK TEMP
Violation Issued: No

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

THIS INSPECTION IS PART OF AN HRD SURVEY OF AN ASSISTED LIVING FACILITY.
MET WITH LEAD SURVEYOR MARY CARROLL AND JOHN SHERIDAN-GIESE (WITH HRD) AND KATIE STADTHER-LALD AND KUNISHA ANDERSON-KM-H.

THIS ESTABLISHMENT HAS A SINGLE KITCHEN FOR FOOD PREP THAT IS CONNECTED TO A COMMUNAL DINING AREA. FLOORS 5 AND 6 RECEIVE PLATED MEALS FROM THE MAIN KITCHEN WHICH ARE THEN HANDED OUT DIRECTLY TO RESIDENTS ON THOSE FLOORS.

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 7963211164 of 12/09/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Kunisha Anderson
Person in Charge

Signed:_____
Peggy Spadafore
Sanitatian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us