Electronically delivered

April 25, 2022

Administrator
Emerald Crest Of Shakopee
1855 10th Avenue West
Shakopee, MN 55379

RE: Project Number(s) SL21389015

Dear Administrator:

On April 8, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on November 5, 2021. The follow-up evaluation determined your agency had corrected all of the state licensing orders issued pursuant to the November 5, 2021 evaluation.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

Also, at the time of this follow-up evaluation completed on April 8, 2022, we identified the following violation(s):

0130-Application For Licensure-144g.12, Subd. 1

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.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(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 assisted living facility'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 §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.

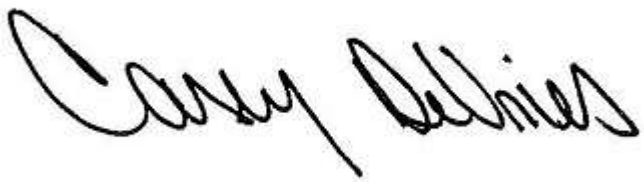
CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received 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
Health.HRD.Appeals@state.mn.us

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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 facility's Governing Body.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21389	A. BUILDING: _____ B. WING _____	R 04/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF SHAKOPEE	1855 10TH AVENUE WEST SHAKOPEE, MN 55379

(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: Project # SL21389015-2 On April 8, 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 November 5, 2021, and January 19, 2022. At the time of the survey, there were 34 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following order was issued.	{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.	
0 130 SS=F	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130		

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130		

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130		

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130		

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to meet the requirements of licensure for the assisted living with dementia care license they possessed. This had the potential to affect all 34 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). Findings include: The licensee's assisted living with dementia care license, effective August 1, 2021, indicated a capacity of 33 assisted living with dementia care residents. During the follow up survey entrance conference on April 8, 2022, at approximately 9:50 a.m., the surveyor requested a current resident list. At 10:38 a.m., registered nurse (RN)-A provided the current resident list, which included 34 residents.	0 130		

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0 130	Continued From page 5 When interviewed on April 8, 2022, at 10:47 a.m., regional director of operations (RDO)-F verified the licensed resident capacity was 33 and confirmed the licensee's current census was 34. RDO-F stated the licensee was aware they had a capacity above the licensed resident capacity. A policy was not available. TIME PERIOD FOR CORRECTION: Two (2) days	0 130		
{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: No further action required.	{0 480}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

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{0 810}	Continued From page 6 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		

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{02040}	Continued From page 7	{02040}		
{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. This MN Requirement is not met as evidenced by: No further action required.	{02040}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 1, 2022

Administrator
Emerald Crest Of Shakopee
1855 10th Avenue West
Shakopee, MN 55379

RE: Project Number(s) SL21389015

Dear Administrator:

On January 19, 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 November 5, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the November 5, 2021 evaluation.

In accordance with Minn. Stat. § 144A.474, Subd. 11, state licensing orders issued pursuant to the last evaluation completed on November 5, 2021, found not corrected at the time of the January 19, 2022 follow-up evaluation and subject to penalty assessment are as follows:

0460-Minimum Requirements-144g.41 Subdivision 1 = $500.00
0470-Minimum Requirements-144g.41 Subdivision 1 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on January 19, 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.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, **the total amount you are assessed is $4,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on January 19, 2022, we identified the following violation(s):

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

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.

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
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

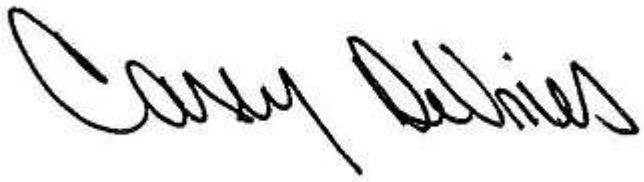
Alternatively, in accordance with Minn. Stat. § 144A.474, Subd. 11(g) , a home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144A.475, Subd. 4 and Subd. 7, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

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{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: Project # SL21389015-1 On January 18, 2022 and January 19, 2021, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 5, 2021. At the time of the survey, there were 32 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued. An immediate correction order was identified on January 19, 2022, issued for SL21389015-1, tag identification 2070. On January 20, 2022, the immediacy of correction order 2070 was removed, however non-compliance remained at a scope and level of I.	{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 Home Care 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 SUBDIVISION 1-3.	

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{0 460}	Continued From page 1	{0 460}		
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week, as required. This had the potential to affect all 32 residents 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	{0 460}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21389	A. BUILDING: _____ B. WING _____	R 01/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF SHAKOPEE	1855 10TH AVENUE WEST SHAKOPEE, MN 55379

(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
{0 460}	Continued From page 2 portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 33 residents. During the initial survey entrance conference on November 2, 2021, at approximately 11:32 a.m., when the surveyor asked how the residents summoned staff when needed, registered nurse (RN)-A and regional director of operations stated all memory care staff "round" frequently and anticipated residents' needs, and residents were in the common areas of the house during awake times so they could be observed. RN-A and the regional director of operations confirmed the facility did not have a call system in place for residents to request assistance when needed. During the initial tour of the facility with the health support specialist on November 2, 2021, at approximately 12:17 p.m., the surveyor observed the facility consisted of three (3) separate secure units (houses), which were all connected by hallways, and were secured with keypad entrances. Each secure unit housed residents with similar levels of dementia. The census of the facility at that time was 33 residents. On January 18, 2022, at approximately 12:30 p.m., during a revisit to the licensee, the surveyor reviewed the documentation the licensee presented as evidence of corrections made after the initial survey. The documentation included information related to the design of the building, regular cares provided to the residents and explanation of how program/meal structure allow for staff to be consistent and have regular	{0 460}		

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{0 460}	Continued From page 3 interaction with all residents throughout the day and night. The licensee also included, residents reside in a house with a common area in the middle and resident rooms surrounding and resident cares allow staff to interact with each resident throughout the day. During the overnight, staff are awake and in common areas to be ready to determine resident needs and staff perform regular rounds to check on all residents. Further, the documentation included, "No pendants are available for use at this time and this has been updated in our UDALSA [Uniform Disclosure of Assisted Living Services and Amenities] and staffing plan." The Emerald Crest of Shakopee Direct-Care Staffing Plan updated November 12, 2021, identified the licensee determined the adequate number of staff by reviewing customer feedback, service plans, and reports of services being completed in a timely fashion. The plan also indicated nurses would adjust the schedule if there were concerns and all resident services were reviewed at a minimum of every 90 days, as well as if there was a change in condition. The previous statement, "Emergency pendant response times will be reviewed to ensure that staff are able to timely meet the residents scheduled and reasonably foreseeable unscheduled needs;" was removed from this updated plan. The licensee provided a UDALSA, dated May 31, 2021, as evidence of the updated version, which no longer included the statement that pendants were available in Vine House (house #3), and in other houses, "staff to anticipate resident needs as well as round and do checks. Resident inability to press pendant."	{0 460}		

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{0 460}	Continued From page 4 During the exit conference on January 19, 2022, at approximately 4:00 p.m., the regional director of operations stated she was confused about the citation and thought the licensee just needed to update the UDALSA and staffing plan to remove the statements about pendant use in the facility. The licensee's Pendant-Call Light policy, indicated the staff would respond to summoning devices such as a call light, call cord, etc. promptly; however, lacked a policy regarding providing a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week, when a summoning device was not available. No further information was provided.	{0 460}		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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:	{0 470}		

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{0 470}	Continued From page 5 (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 interview and record review, the licensee failed to ensure the required staffing plan was developed to determine staffing levels to meet the needs of all residents as required. This had the potential to affect all 32 current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to develop a staffing plan that ensured that one or more persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents for assistance with health or safety needs as required. The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 33 residents.	{0 470}		

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{0 470}	Continued From page 6 During the revisit survey on January 19, 2022, at approximately 8:30 a.m., the surveyor observed a staff posting, incorrectly dated, Wednesday, January 18, 2022, in the entryway of House 3, also referred to as Vine. The surveyor requested to review the licensee's staffing plan and staffing schedule, which indicated three ULP were scheduled to work between the hours of 11:00 p.m. to 7:00 a.m., with no licensed or ancillary staff scheduled. Review of the licensee's Direct-Care Staffing Plan, revised November 12, 2021, incorrectly indicated the licensee had the ability to service up to 43 residents, and indicated between the hours of 11:00 p.m. and 7:00 a.m., there would be direct care staff able to respond to a resident's request for assistance with health and safety needs within a reasonable amount of time. The plan indicated the staff would be located in the same house in order to respond within a reasonable amount of time. The physical layout of the facility consisted of three separate houses secured by coded entry, each connected by a hallway, also with coded entry. House 1, also known as Spring, had 11 residents residing and receiving services. House 2, also known as Marigold, had 9 residents residing and receiving services. House 3, also known as Vine, had 12 residents residing and receiving services. All residents had diagnoses including cognitive impairment, Alzheimer's Disease, or dementia. The current total census was 32 residents who received assisted living services. On January 18, 2022, at approximately 3:50 p.m., ULP-M stated she occasionally worked the night	{0 470}		

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{0 470}	Continued From page 7 shift and verified the licensee regularly staffed one ULP per house at night. ULP-M stated, if something happened in one of the other houses, ULPs would call each other for help, which required a ULP to leave their assigned house unattended. ULP-M stated staff would open the doors to the hallway (normally closed) leading to the next house and would go back and forth between the houses to check on the residents. ULP-M stated in the past when there were more residents, the licensee always scheduled a float person that would go where help was needed. On January 19, 2022, at approximately 10:05 a.m., ULP-N stated she occasionally worked the night shift and verified the licensee regularly staffed one ULP in each house for a total of three ULP during the night shift. ULP-N stated if she needed help from another staff, she would call on her cell phone to another house and a ULP would come and help. ULP-N stated the staff leave the doors open between houses so the staff can run back and forth to check on the other residents. During an interview on January 19, 2022, at approximately 11:28 a.m., registered nurse (RN)-A verified the staffing schedule and stated three ULP were scheduled for the night shift. RN-A stated no full body lifts were used for any resident, and only one resident in House 3 required assistance of two staff for transfers and toileting, due to a recent fall. RN-A stated most residents slept through the night, however, if something were to happen, everyone is willing to help, so staff call another house, because the houses are linked. RN-A stated staff leave the doors open to the adjoining houses so they could hear residents. RN-A stated, "That's how it's been for years."	{0 470}		

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{0 470}	Continued From page 8 The licensee's Staffing policy dated July 13, 2021, indicated the staffing plan would provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven-days a week and would be adequate to address each resident's needs as identified in the service plan and assisted living contract, each resident's acuity level, the ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility, staff competency and training, and would indicate if the assisted living had a secured dementia care unit. No further information was provided.	{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:	{0 480}		

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{0 480}	Continued From page 9 No further action required.	{0 480}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced	{0 810}		

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{0 810}	Continued From page 10 by: No further action required.	{0 810}		
{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. This MN Requirement is not met as evidenced by: No further action required.	{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	02070	On January 20, 2022, the immediacy of correction order 2070 was removed,	

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02070	Continued From page 11 persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in the secured dementia care unit. This resulted in an immediate correction order issued on January 19, 2022. 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 held an Assisted Living with Dementia Care license with a bed capacity of thirty-three (33) residents. The licensee failed to ensure one or more staff were always available during the night shift in each of the three separate secured dementia care units. During the initial survey entrance conference on November 2, 2021, at approximately 11:32 a.m., the surveyor asked how the residents summoned staff when needed. Registered nurse (RN)-A and regional director of operations stated all memory care staff "round" frequently and anticipated residents' needs, and residents were in the common areas of the house during awake times so they could be observed. RN-A and the regional director of operations confirmed the facility did not have a call system in place for residents to	02070	however non-compliance remains at a scope and level of I.	

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02070	Continued From page 12 request assistance when needed. On January 19, 2022, at approximately 8:30 a.m., during a revisit to the facility, the surveyor observed the staff posting, incorrectly dated, Wednesday, January 18, 2022, in the entryway of House 3, also referred to as Vine. The surveyor requested to review the licensee's staffing plan and staffing schedule, which indicated three ULP were scheduled to work between the hours of 11:00 p.m. to 7:00 a.m., with no licensed or ancillary staff scheduled. The physical layout of the facility consisted of three separate houses secured by coded entry, each connected by a hallway, also with coded entry. House 1, also known as Spring, had 11 residents residing and receiving services. House 2, also known as Marigold, had 9 residents residing and receiving services. House 3, also known as Vine, had 12 residents residing and receiving services. All residents had diagnoses including cognitive impairment, Alzheimer's Disease, or dementia. The current total census was 32 residents who received assisted living services. On January 18, 2022, at approximately 3:50 p.m., ULP-M stated she occasionally worked the night shift and verified the licensee regularly staffed one ULP per house at night. ULP-M stated, if something happened in one of the other houses, ULPs would call each other for help, which required a ULP to leave their assigned house unattended. ULP-M stated staff would open the doors to the hallway (normally closed) leading to the next house and would go back and forth between the houses to check on the residents. ULP-M stated in the past when there were more residents, the licensee always scheduled a float	02070		

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02070	Continued From page 13 person that would go where help was needed. On January 19, 2022, at approximately 10:05 a.m., ULP-N stated she occasionally worked the night shift and verified the licensee regularly staffed one ULP in each house for a total of three ULP during the night shift. ULP-N stated if she needed help from another staff, she would call on her cell phone to another house and a ULP would come and help. ULP-N stated the staff leave the doors open between houses so the staff can run back and forth to check on the other residents. During an interview on January 19, 2022, at approximately 11:28 a.m., registered nurse (RN)-A verified the staffing schedule and stated three ULP were scheduled for the night shift. RN-A stated no full body lifts were used for any resident, and only one resident in House 3 required assistance of two staff for transfers and toileting, due to a recent fall. RN-A stated most residents sleep through the night, however, if something were to happen, everyone is willing to help, so staff call another house, because the houses are linked. RN-A stated staff leave the doors open to the adjoining houses so they could hear residents. RN-A stated, "That's how it's been for years." During an observation on January 19, 2022, at approximately 11:45 a.m., in the presence of the surveyor, maintenance (M)-O measured the distance in the hallway between House 1 and House 2, noting 47 feet between entrance doors, and 32 feet between the doors of House 2 and House 3. Review of the licensee's Direct-Care Staffing Plan, revised November 12, 2021, indicated between the hours of 11:00 p.m. and 7:00 a.m.,	02070		

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02070	Continued From page 14 there would be direct care staff able to respond to a resident's request for assistance with health and safety needs within a reasonable amount of time. The plan indicated the staff would be located in the same house in order to respond within a reasonable amount of time. The licensee's policy, Staffing, dated July 13, 2021, indicated, at all hours direct-care staff would respond to a resident request for assistance with health or safety needs within a reasonable amount of time, and a minimum of two direct-care staff would be scheduled and available to assist at all times whenever a resident required the assistance of two. The policy also directed one or more persons would be available 24-hours per day, seven days per week, who were responsible for responding to the request of residents for assistance for health and safety needs. Person would be awake, located in the same building or an attached building or on a contiguous campus within the facility, in order to respond within a reasonable amount of time. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On January 20, 2022, the immediacy of correction order 2070 was removed following supervisor review of licensee's plan of correction, however non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) days	02070		

Electronically Delivered

November 24, 2021

Administrator
Emerald Crest Of Shakopee
1855 10th Avenue West
Shakopee, MN 55379

RE: Project Number(s) SL21389015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 5, 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 Home Care 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 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

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-696-2437 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21389	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF SHAKOPEE	1855 10TH AVENUE WEST SHAKOPEE, MN 55379

(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#21389015 On November 2, 2021, through November 5, 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 33 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 Home Care 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 SUBDIVISION 1-3.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460		

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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week, as required. This had the potential to affect all 33 residents 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 460		

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0 460	Continued From page 2 The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 33 residents. During the entrance conference on November 2, 2021, at approximately 11:32 a.m. when asked how the residents summoned staff when needed, registered nurse (RN)-A and regional director of operations stated all memory care staff "round" frequently and anticipated residents' needs, and residents were in the common areas of the house during awake times so they could be observed. RN-A and the regional director of operations confirmed the facility did not have a call system in place for residents to request assistance when needed. During the initial tour of the facility with the health support specialist on November 2, 2021, at approximately 12:17 p.m., it was observed the facility consisted of three (3) separate secure units (houses) which were all connected by hallways, and secured with keypad entry. Each secure unit housed residents with similar levels of dementia. The current census at the facility was 33 residents. The Emerald Crest of Shakopee Direct-Care Staffing Plan dated July 29, 2021, identified the adequate number of staff was determined by individualized services plans and the needs of each resident in each house and included, "Emergency pendant response times will be reviewed to ensure that staff are able to timely meet the residents scheduled and reasonably foreseeable unscheduled needs;" however, the licensee did not utilize a pendant system.	0 460		

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0 460	Continued From page 3 The undated Uniform Disclosure of Assisted Living Services and Amenities, which is provided to residents upon admission, indicated on page 3, pendants were available in Vine House (house #3), and in other houses, "staff to anticipate resident needs as well as round and do checks. Resident inability to press pendant." On November 2, 2021, at approximately 3:40 p.m. the regional director of operations verified pendants were not in use, due to residents' inability to use them. The licensee's Pendant-Call Light policy, indicated the staff would respond to summoning devices such as a call light, call cord, etc, promptly; however, lacked a policy regarding providing a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week, when a summoning device was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for 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	0 470		

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0 470	Continued From page 4 (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 interview and record review, the licensee failed to ensure the required staffing plan was developed to determine staffing levels to meet the needs of all residents. This had the potential to affect all 33 current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee failed to develop and implement a	0 470		

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0 470	Continued From page 5 staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility. The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 33 residents. During the entrance conference on November 2, 2021, at approximately 11:32 a.m. when asked how the residents summoned staff when needed, registered nurse (RN)-A and regional director of operations stated all memory care staff "rounded" frequently and anticipated residents' needs, and residents were in the common areas of the house during awake times so they could be observed, and were provided activities to engage them. The Emerald Crest of Shakopee Direct-Care Staffing Plan dated July 29, 2021, incorrectly identified the facility had the ability to serve up to 43 residents, instead of the current licensure for 33 residents. The staffing plan indicated six unlicensed personnel (ULP) from 7:00 a.m. to 3:00 p.m., six ULP from 3:00 p.m. to 11:00 p.m., and three ULP from 11:00 p.m. to 7:00 a.m., and indicated the staffing plan would be reviewed during quality management meetings, at a minimum, two times each year, and would be updated as needed. The staffing plan identified the adequate number of staff was determined by individualized services plans and the needs of each resident in each house and included, "Emergency pendant response times will be reviewed to ensure that staff are able to timely meet the residents scheduled and reasonably foreseeable unscheduled needs;" however, the licensee did not utilize a pendant system.	0 470		

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0 470	Continued From page 6 On November 2, 2021, at approximately 3:25 p.m. RN-A stated she had worked at the facility for 20 years, and the staffing plan had "always been that way," with six ULP on day shift and evening shift, and three ULP on night shift. On November 2, 2021, at approximately 3:40 p.m. the regional director of operations stated the number of staff needed was determined by the staffing plan. When asked about the staffing plan indicating the emergency pendant response times would be reviewed to ensure staff response to meet the needs of the residents, the regional director of operations verified pendants were not in use, therefore, response times could not be measured. The licensee's Staffing policy dated July 13, 2021, indicated the staffing plan would provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven-days a week and would be adequate to address each resident's needs as identified in the service plan and assisted living contract, each resident's acuity level, the ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility, staff competency and training, and would indicate if the assisted living had a secured dementia care unit. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 7 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 2, 2021, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 8 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 and current recommendations for COVID-19, and failed to ensure used sharps were disposed of properly. This deficient practice had the potential to affect the licensee's 33 current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 510		

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0 510	Continued From page 9 or has the potential to affect a large portion or all the residents). The findings include: SCREENING OF VISITORS On November 3, 2021, at approximately 12:10 p.m. the doorbell in house #3 rang, and unlicensed personnel (ULP)-A went to answer the door. An unidentified male entered the facility, donned a mask, and walked through the common area, into a resident's room. When interviewed on November 3, 2021, at approximately 12:15 p.m. ULP-A stated she did not take the male visitor's temperature when he entered, and didn't know if he had answered the COVID-19 screening questions, because visitors "screened themselves." An Employee-Visitor-Vendor Screening Tool located by the front entrance door was reviewed. The male visitor documented the following: he had no symptoms, was not fully vaccinated, had not had close contact in the last 14 days with someone who was infected with COVID-19, and indicated he had performed proper hand hygiene when entering the facility. No temperature was recorded. On November 3, 2021, at approximately 12:35 p.m. registered nurse (RN)-B stated staff were responsible for checking visitors' temperature when they entered the facility and ensuring they completed the screening tool and were appropriate to enter. The licensee's Visitation Update posted near the entrance included direction to staff to make sure everyone entering completed the screening and	0 510		

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0 510	Continued From page 10 his or her temperature was taken. PERSONAL PROTECTIVE EQUIPMENT (PPE) On November 4, 2021, at approximately 8:47 a.m. ULP-D was observed while passing medications in the dining room in house #2. ULP-D wore a medical-grade mask and her own eyeglasses, with plastic clip-on side shields. On November 4, 2021, at approximately 3:45 p.m. the director of clinical services indicated she was not aware the plastic clip-on side shields were not considered appropriate eye protection for health care workers. DISPOSAL OF SHARPS On November 4, 2021, at approximately 8:15 a.m. ULP-A prepared to perform blood glucose testing for R1. ULP-A approached R1 in the common area and announced that she needed to check his blood glucose, and was directed to take him to his room for the procedure, by RN-B. ULP-A donned gloves, used an alcohol pad to wipe the finger, used a lancet to poke the finger, and performed the blood glucose test. ULP-A removed her gloves, removed the gloves with the lancet still in the glove, and threw the gloves and the lancet into the garbage container in R1's bathroom. ULP-A left R1's room, went into the kitchen area, and washed her hands in the sink. ULP-A went into the medication room and put R1's glucometer into the medication cart. When asked where she put the lancet, ULP-A stated, "I threw it away. I don't know where else to put it." A female staff member in the medication room pointed to the sharps container on the shelf next to the medication cart. ULP-A stated, "If I would have known that, I would have put it there. No one ever told me." When asked who trained her, ULP-A stated, "I don't even know."	0 510		

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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
0 510	Continued From page 11 On November 4, 2021, at approximately 12:19 p.m. RN-A indicated staff were trained during medication administration training to dispose of sharps in the appropriate sharps container, not in the garbage. The licensee's Disposal of Contaminated Material and Equipment, reviewed October 4, 2021, indicated, any disposable equipment that is sharp, such as lancets, needles, syringes, razor blades, must be disposed of in the sharps container. The licensee's COVID-19 Protocol, reviewed October 22, 2021, directed, "Employees will wear eye protection in resident care areas based on your state requirements. Eye protection can include safety glasses which cover the side of the eyes, goggles or a face shield." In addition, the policy directed, "Visitors, vendors, staff and volunteers entering the building will be screened for symptoms of COVID-19. This includes documenting the absence of shortness of breath, new or change in cough, new onset of sore throat and a temperature check. This will be completed upon entrance to the facility." The Minnesota Department of Health Infection Prevention and Control: COVID-19 electronic guidance for infection prevention and control in health care settings, dated August 2, 2021, indicated MDH recommends eye protection for all health care workers (HCW) in all resident care areas and when providing direct care. The Centers for Disease Control and Prevention (CDC) COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019	0 510		

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	21389	A. BUILDING: _____ B. WING _____	11/05/2021

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0 510	Continued From page 12 (COVID-19) Pandemic, dated September 10, 2021, indicated eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required information related to the licensee's grievance procedure to include contact information for the state and applicable regional Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all 33 residents, staff, and visitors. This practice resulted in a level two violation (a	0 550		

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0 550	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting to include all of the required content about the facility's grievance procedure to include the contact information for the state and applicable regional Office of Ombudsman for Mental Health and Developmental Disabilities. During a facility tour on November 2, 2021, at approximately 12:58 p.m. the main entrance of each of three buildings included a sign that directed visitors and staff to a binder on the table in the entryway. The binder contained, but was not limited to, the Minnesota Bill of Rights for Assisted Living Residents, Disaster Plan, Staffing Plan, and an undated MN (Minnesota) Notice to Clients on How to Submit a Complaint. The notice included the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center; however, it lacked contact information for the state and the applicable regional Office of Ombudsman for Mental Health and Developmental Disabilities, as required. On November 4, 2021, at approximately 3:10 p.m. the regional director of operations confirmed the required content noted above was	0 550		

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0 550	Continued From page 14 not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 550		
0 620 SS=D	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to immediately report an incident to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R3) who did not return to the facility, after being allowed to leave the facility against the family's wishes, 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).	0 620		

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0 620	Continued From page 15 The findings include: On November 2, 2021, at approximately 11:45 a.m. a request was made to the director of clinical services, registered nurse (RN)-A, and the regional director of operations to review all vulnerable adult reports the licensee had made to MAARC in the past six months, to which they indicated no MAARC reports had been submitted. On November 3, 2021, at approximately 9:45 a.m. R3 was observed in the dining room, sitting with a male and a female resident, taking his medications from a plastic cup and putting them in his mouth. R3 was admitted to the facility on July 22, 2021, with diagnoses which included, but were not limited to, depression, alcohol abuse, and dementia. R3's Service Plan dated July 7, 2021, indicated R3 received services that included assistance with activities of daily living, escort/invite to meals, cueing with mobility, toileting, behaviors with verbal re-direction, and medication management. R3's Assessment for Client Vulnerability, Safety, and Risk to Others dated October 31, 2021, indicated R3 had behaviors posing a risk to himself, and "Due to past history of alcoholism and others taking financial advantage of resident he needs a secured environment due to poor judgement for his own safety/security. Keep resident engaged in daily activities to keep him busy. Allow him to socialize with others during mealtime and activities. Report any concerns to nursing/OT [occupational therapy]."	0 620		

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0 620	Continued From page 16 R3's progress notes indicated on September 17, 2021, at 4:02 p.m. R3 became agitated when he asked a staff member to give him a ride to the dry cleaners and she left at the end of her shift without taking him. R3's daughter and power of attorney (POA), was contacted and directed R3 was not to go anywhere with anyone other than family. On September 20, 2021, at 2:38 p.m. R3 was requesting to go to the bank and wanted to give money to a friend. R3's POA was contacted and gave permission for him to go out with his friend, as long as she picked him up, and stated R3 had limited access to his money. R3 signed out and left the facility at 3:20 p.m. with a female. At 8:00 p.m., R3 had not returned to the facility and staff contacted R3's POA, whom stated she would locate him by cell phone. At 9:20 p.m., R3 returned to the facility smelled of alcohol, and admitted to the staff that he had been drinking at the Legion. R3 was very loud, yelling, and verbally abusive toward staff upon his return. On September 21, 2021, at 11:28 a.m. R3's POA was updated, stated she did not know the female friend that picked him up, and again stated R3 was not to go out with anyone but family. On September 25, 2021, at 8:09 p.m. R3 left the facility with the same female friend because the unlicensed personnel (ULP) on duty was not aware that R3 was not allowed to leave the facility except with family. Registered nurse (RN)-B attempted to locate R3 at places he had frequented in the past, and the police were notified. On September 26, 2021, at 12:00 a.m. a police officer called RN-B, and stated the female friend	0 620		

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0 620	Continued From page 17 had been contacted, and she reported leaving R3 at the Legion. The police officer went to that location and R3 was not there, so went to the Veterans of Foreign War (VFW) a block away, and spotted R3 walking on the sidewalk in front of the VFW. RN-B was able to get R3 into the car to go back to the facility. R3 smelled of alcohol and cigarette smoke, and had an unsteady gait. R3's POA was notified R3 was located and returned to the facility, and was okay. On November 4, 2021, at approximately 3:29 p.m. director of clinical services and RN-A stated no MAARC report was filed when R3 left the facility, could not be located, and did not return until he was located by the police, and stated staff would be reeducated. The licensee's Abuse Prohibition-AL-MN policy reviewed June 4, 2021, indicated each employee is responsible to immediately report all alleged violations and substantiated incidents involving vulnerable adults, to the state agency, orally or online, to MAARC, and all other agencies as required. The licensee's Missing Resident Plan revised October 21, 2021, indicated the Department of Health or the designated State Agency for reporting of a missing vulnerable adult (VA) would be notified and a complete initial report would be filed per state and federal regulations. Also included, appropriate final VA report or notification of the State Agency would be provided, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		

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0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of five employees (registered nurse (RN)-B, unlicensed	0 650		

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0 650	Continued From page 19 personnel (ULP)-A), 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: RN-B RN-B had a start date of September 7, 2021. RN-B's record lacked evidence of the following: - current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; and - documentation of the background study as required under section 144.057. ULP-A ULP-A had a start date of September 6, 2021. ULP-A's record included a Background Study Notice dated September 3, 2021, that indicated "MORE TIME IS NEEDED TO COMPLETE BACKGROUND STUDY;" however, it lacked evidence the background study was clear. On November 4, 2021, at approximately 11:45 a.m. the regional director of operations verified the above contents were missing from the employee records. On November 4, 2021, at approximately 12:33 p.m. RN-A provided copies of RN-B and ULP-A's	0 650		

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0 650	Continued From page 20 background study clearances, which she stated were printed from the website. The licensee's Content of Employee Records-AL dated July 13, 2021, indicated records must include, but were not limited to, current job description, including qualifications, responsibilities, and identification of staff providing supervision, and documentation of the background study as required under section 144.057. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	0 660		

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0 660	Continued From page 21 Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of five employees (unlicensed personnel (ULP)-B, ULP-A) 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: During the entrance conference on November 2, 2021, at approximately 11:32 a.m. with the director of clinical services, regional director of operations, and registered nurse (RN)-A, a request was made to review the facility TB risk assessment. The TB risk assessment provided was dated June 16, 2021, and indicated the licensee was a "low risk." ULP-B had a start date of June 17, 2019. ULP-B's employee record lacked evidence of a completed TB history and symptom screening, including completion of a two-step TST or other evidence of TB screening such as a blood test, as	0 660		

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0 660	Continued From page 22 required. ULP-A had a start date of September 6, 2021. ULP-A's employee record contained evidence of a completed TB history and symptom screening dated September 3, 2021; however, the record lacked evidence of completion of a two-step TST or other evidence of TB screening such as a blood test, as required. On November 4, 2021, at approximately 12:33 p.m. regional director of operations confirmed ULP-B and ULP-A's records did not contain the above documents. The licensee's Tuberculosis Prevention and Screening-AL-MN policy revised September 30, 2021, indicated all paid and unpaid health care workers would receive a baseline TB screening to include an evaluation of risk factors for active TB disease and testing for the presence of infection with tuberculosis by either a two-step TST, including the first step prior to starting work, or a single TB blood test, and all reports would be maintained by the facility. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with	0 660		

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0 660	Continued From page 23 patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 24 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the facility failed to require evacuation drills twice per year per shift with at least one evacuation drill every other month, as required by MN Statute 144G.45 Subd.2(f). This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 November 2, 2021, between 11:50 a.m. and 12:15 p.m. an interview and record review was conducted with the Health Support Specialist (HSS) on evacuation drills for employees. Based on this record review, the facility had a policy that required fire safety and evacuation drills to be conducted twice per year per shift with one evacuation drill every other month; however, there was no documentation indicating they had conducted any evacuation drills for employees. The HSS indicated that the facility did have this in policy, but ceased conducting the drills with the onset of COVID and the drills had not been	0 810		

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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
0 810	Continued From page 25 resumed at this time. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01610 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for one of one resident (R2) as required, with records reviewed.	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21389	A. BUILDING: _____ B. WING _____	11/05/2021

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01610	Continued From page 26 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: R2 was admitted for services on August 24, 2021. R2's diagnoses included, but were not limited to, generalized anxiety disorder and unspecified dementia. On November 4, 2021, at approximately 8:47 a.m. R2 was observed sitting at the dining room table, sipping from a plastic mug with a straw, and pushing her plate with eggs and toast, away, stating she didn't want it. R2's service plan dated August 19, 2021, indicated R2 received services including, but not limited to, assistance with bathing, dressing, grooming, mobility, transfers, toileting, behavior redirection, medication administration, meals, and vital signs monitoring. R2's Assisted Living Contract was signed August 24, 2021. R2's record included a RN Assessment dated August 25, 2021, and was signed by the RN on September 7, 2021, not prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moves in, whichever was earlier, as required.	01610		

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01610	Continued From page 27 On November 4, 2021, at approximately 3:55 p.m. registered nurse (RN)-A confirmed R2's assessment was not completed until one day after R2 moved in to the facility. The licensee's Initial, Ongoing and Change in Condition Assessment-Evaluation of Residents-AL-MN policy revised September 27, 2021, indicated a registered nurse would coordinate the comprehensive nursing assessments of the resident's physical, mental, and cognitive needs, as required, to include an admission assessment, 14 day assessment, and ongoing assessment no less than every 90 days, and change in resident assessment. The policy did not specify the required initial assessment time frame. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	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	01620		

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01620	Continued From page 28	01620		

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 conduct an ongoing resident reassessment and monitoring, as needed based on changes in the needs of the resident for two of two residents (R1, R2), 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:

R1
R1 sustained lacerations to his head after two separate falls on October 27, 2021, and was transported by ambulance to the hospital after each fall. R1's record lacked a reassessment by the registered nurse (RN) to determine causal

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01620	Continued From page 29 factors and consider new care plan interventions for prevention of future risk for falls. R1 was admitted to the facility on April 8, 2021, with diagnoses including, but not limited to, dementia, type 2 diabetes, and anxiety. R1's most recent RN Assessment dated October 14, 2021, indicated R1 was "high risk" for falls. R1's Individual Abuse Prevention Plan (IAPP) dated October 14, 2021, indicated R1 was vulnerable for falls, and included, "[R1] is at risk due to age and physical decline. [R1] has had no recent falls. Report any changes in mobility to nursing." A Resident-Visitor Incident Report dated October 27, 2021, at 9:00 a.m. indicated R1 was found on the floor in his room, and had a deep cut on the back of his head with "a lot" of bleeding. The report indicated 911 was called by the nurse and family was notified. RN-A signed the report on October 27, 2021, indicating she had reviewed the report. R1's Progress Notes dated October 27, 2021, at 10:06 a.m. indicated R1 reported not feeling well while sitting in the dining room and was escorted to his room per his request by RN-B. RN-B left the room to get R1's glucometer (device for checking blood sugar) and a glass of orange juice. When RN-B returned, R1 was found lying on his back on the floor, with a laceration to his head. R1's blood sugar was 23. Orange juice was given and 911 was called. R1 returned to the facility later that afternoon with sutures for the laceration. A Resident-Visitor Incident Report dated October	01620		

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01620	Continued From page 30 27, 2021, at 8:40 p.m. indicated R1 was found lying on the floor in his room, outside of his bathroom. The report indicated R1's head was bleeding, and he did not reply when asked questions about the fall. RN-B was notified at 8:45 p.m. and directed staff to call 911. R1's nurse practioner was also notified. RN-A signed the report on October 28, 2021, indicating she had reviewed the report. R1's Progress Notes dated October 27, 2021, at 8:57 p.m. indicated R1 fell, head was bleeding, and R1 was "thrashing around on the floor." Unlicensed personnel was unable to assess blood glucose or blood pressure, and reported R1's "eye rolling back of his head." 911 was called and R1 was sent to the hospital to be evaluated. Family was notified. On October 28, 2021, at 2:55 p.m. a progress note indicated R1 returned from the hospital emergency room at 4:00 a.m. with no new orders, and had sutures to the back/top of his head. R1 denied pain or discomfort and remained at baseline with cognition. Staff were directed to monitor and stand by assist with ambulation for safety. R1's record lacked a reassessment by the RN to determine causal factors and consider new care plan interventions for prevention of future risk for falls. R2 R2 sustained multiple falls since admission. R2's record lacked a reassessment by the RN to determine causal factors and consider new care plan interventions for prevention of future risk for falls.	01620		

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01620	Continued From page 31 R2 was admitted to the facility on August 24, 2021, with diagnoses including, but not limited to, unspecified dementia and generalized anxiety. R2's RN Assessment (admission) dated August 25, 2021, and most recent RN Assessment dated September 7, 2021, indicated R2 was "very high risk" for falls. R2's IAPP dated September 7, 2021, indicated R2 was vulnerable for chronic pain and included, "[R2] has had multiple falls at home and may have pain. Let nurse know if she is having pain." In addition, the plan indicated R2 was vulnerable for falls and included, "Resident has a history of multiple falls while at home. Report any changes in mobility to nursing/OT [occupational therapy]." R2's OT Assessment dated August 25, 2021, indicated R2 had a history of falls, with family reporting numerous falls with injury. The assessment also included, "Unsteady: Resident has had multiple falls with injury. She is very high falls risk and needs close supervision for safety. A Resident-Visitor Incident Report dated September 16, 2021, at 10:30 p.m. indicated R2 reported she was trying to go to bed in her room. The report did not indicate where the resident was found or if the fall was witnessed, but it indicated no injuries or complaints of pain. The on-call nurse was notified of the fall. RN-B was notified on September 17, 2021, and documented "Staff to [decrease] noise in the [not legible] to help [decrease] anxiety. Frequent check on resident. If resident showing signs of [increased] anxiety." R2's nurse practitioner and family were notified on September 17, 2021. RN-A signed the report on September 20, 2021, indicating she had reviewed the report.	01620		

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01620	Continued From page 32 R2's Progress Notes lacked documentation of the fall. A Resident-Visitor Incident Report dated October 1, 2021, (time of incident was left blank) indicated R2 had a fall with no apparent injury, had increased agitation that caused the fall, and staff were closely monitoring post fall. RN-B, R2's physician, and family were notified on October 1, 2021. The report lacked a signature to indicate the report had been reviewed. R2's Progress Notes dated October 1, 2021, at 3:26 p.m. indicated R2 was heard screaming/crying and staff found resident lying on the floor on her right side. R2 had no pain or discomfort with movement, and the fall was reported to the physician and family. A Resident-Visitor Incident Report dated October 17, 2021, at 2:30 (no indication of a.m. or p.m.) indicated R2 was found on the floor in front of the couch, with no apparent injuries. On-call RN and RN-B were notified. R2's physician was notified on October 18, 2021. The report lacked a signature to indicate the report had been reviewed. R2's Progress Notes lacked documentation of the fall. R2's Progress Notes dated October 23, 2021, at 8:38 p.m. indicated R2 fell in the dining room, no injuries, and vital signs were within normal limits. R2's family was updated. RN-B instructed unlicensed personnel to call her for any changes in the resident. R2's record lacked an incident report of the fall on	01620		

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01620	Continued From page 33 October 23, 2021. A Resident-Visitor Incident Report dated October 25, 2021, at 7:47 p.m. R2 had a witnessed fall in the living room/dining room area, and hit her head. No bruising was noted and no complaints of pain. The on-call nurse was called twice, RN-B and R2's physician were notified on October 26, 2021. The report lacked a signature to indicate the report had been reviewed. R2's Progress Notes lacked documentation of the fall. R2's record lacked a reassessment by the RN to determine causal factors and consider new care plan interventions for prevention of future risk for falls. On November 4, 2021, at approximately 3:53 p.m. RN-A verified a reassessment was not completed after R1 sustained two separate falls with injury on October 27, 2021, requiring transport to the hospital emergency department with each fall, and verified there were no new interventions or changes to address fall risk and prevent future falls. In addition, RN-A verified a reassessment was not completed after R2 sustained five falls since admission, and verified there were no new interventions or changes to address fall risk and prevent future falls. The licensee's Fall Management and Managing Fall Risk-AL policy revised February 27, 2020, directed, in the event of a fall, an incident report would be completed and include the entire investigation of the fall. Investigation would include all applicable team members, and would attempt to identify root cause of the fall. Also included, the interdisciplinary team would review	01620		

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01620	Continued From page 34 the care plan, and update with any change in interventions. The licensee's Initial, Ongoing and Change in Condition Assessment-Evaluation of Residents-AL-MN policy revised September 27, 2021, indicated nursing assessments were coordinated by a RN and based upon the required assessment schedule and as needed based upon resident condition. Also included, the RN will reassess the resident if the resident has a change in condition. At these reassessments, the RN will review the resident's service plan, medication management services and the resident's medications, evaluate the resident's treatment, communicate any new problems or concerns to the resident's health care provider, and update the service plan as necessary based on the resident's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

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01640	Continued From page 35 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure services plans were revised to reflect the current services provided for one of two residents (R3) 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: R3's Service Plan dated July 7, 2021, indicated R3 received services that included assistance with activities of daily living, escort/invite to meals, cueing with mobility, toileting, behaviors with verbal re-direction, and medication administration. The service plan did not include any therapy or treatment management.	01640		

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01640	Continued From page 36 R3's Medication Sheet, titled "set up," for August, 2021, September, 2021, and October, 2021, indicated registered nurse (RN)-A was setting up R3's medication in pill bars weekly. On November 4, 2021, at approximately 3:53 p.m. RN-A verified she was setting up R3's medications into pill bars, for the unlicensed personnel to administer, because his medications came from the Veterans Administration and were in bottles. RN-A verified the service plan had not been revised, as required, to include medication set up and the addition of compression stockings. The licensee's Service Plan Contents AL MN policy dated August 1, 2021, indicated service plans were reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=C	144G.70 Subd. 4 Service plan, implementation, and revisions t (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 37 (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's service plan lacked the following: - method of monitoring staff providing services; and - schedule of monitoring assessments of the resident.	01650		

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01650	Continued From page 38 R2 was admitted for services on August 24, 2021. R2's service plan dated August 19, 2021, indicated R2 received services including, but not limited to, assistance with bathing, dressing, grooming, mobility, transfers, toileting, behavior redirection, medication administration, meals, and vital signs monitoring. The service plan lacked the method of monitoring staff providing services, and incorrectly indicated the schedule of monitoring assessments of the initial comprehensive nursing assessment of the resident were to be conducted within five (5) days of initiating services. On November 4, 2021, at approximately 8:47 a.m. R2 was observed sitting at the dining room table, sipping from a plastic mug with a straw, and pushing her plate with eggs and toast, away, stating she didn't want it. On November 4, 2021, at approximately 3:45 p.m. the director of clinical services confirmed the service plan contained the language from the old regulations regarding the schedule and methods of monitoring assessments of the resident, and verified the same template was utilized for all residents. The licensee's Service Plan Contents AL MN policy dated August 1, 2021, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the RN and/or other licensed professional, and would include, but not limited to, schedule and methods of monitoring assessments and schedule and methods of monitoring staff providing services.	01650		

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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
01650	Continued From page 39 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01750 SS=D	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 (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 two of three unlicensed personnel (ULP-A, ULP-B) demonstrated competency for administering oral medications to residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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:	01750		

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	21389	A. BUILDING: _____ B. WING _____	11/05/2021

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01750	Continued From page 40 The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 33 residents. On November 3, 2021, at 8:50 a.m. registered nurse (RN)-B was observed giving medications to residents in house #3, and stated she was helping today to administer some of the medications because the staff were "running behind." At 9:45 a.m., RN-B told ULP-A and ULP-B that she needed to attend to other duties and they would need to finish giving the remaining residents their medications. On November 3, 2021, at approximately 9:50 a.m. ULP-A went into the medication room and began preparing medications, while ULP-B cleaned dishes from tables following breakfast. Several residents remained in the dining room. ULP-A handed ULP-B medication cups, labeled with residents' names written on a piece of tape, and both began delivering medications to residents in the dining room. ULP-A set a medication cup in front of a resident sitting at a table with two other residents and walked away, leaving the resident to take the medications. ULP-B placed a medication cup in front of another resident and walked away, leaving the resident to take the medications. ULP-B walked from the dining room to a resident's room, picked up a pill with her bare fingers, and made a motion towards his mouth. The resident asked, "What are you doing" and aggressively took the medication cup out of her hand. ULP-B waited while he took the medications. ULP-B then walked to a resident sitting in a chair in the common area, and waited while the resident swallowed the medications.	01750		

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01750	Continued From page 41 On November 3, 2021, at approximately 9:57 a.m. ULP-A stated she set the medications up into the cups, and they both delivered the medications "to get them done faster." ULP-A stated she was taught to set up and administer medications that she set up, and stated it probably wasn't appropriate for ULP-B to administer medications that were set up by ULP-A. When asked about leaving residents' medications for the resident to take without supervision, ULP-A stated it was okay to do that for some residents, depending on who it was, and stated she was not concerned that all of the residents in the house had dementia or that other residents sitting at the table had access to the medications. ULP-A and ULP-B's personnel records included documentation of completing medication administration training and competency testing. On November 3, 2021, at approximately 10:42 a.m. RN-B stated she and RN-A provided medication training and competency testing for new ULP. RN-B stated it was never okay to leave medications in front of a resident for them to take unsupervised, especially residents with dementia and others around them with dementia, and it was not appropriate for anyone to administer medications that they did not set up themselves. RN-B stated the staff needed better training and reeducation. The licensee's Medication Administration by Unlicensed Personnel-AL policy reviewed August 2021, indicated the nurse may delegate the task of administration of medications if the staff person has satisfied the training requirements, has documented that the person has been trained, and has demonstrated competency.	01750		

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01750	Continued From page 42 The licensee's Medication Set Up and Documentation-AL policy reviewed August 2021, indicated nurses would be responsible for medication set-up for later administration by the ULP, and ULP may not set up medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) 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 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 transcribed and administered as prescribed for one of four residents (R6) with records reviewed. This practice resulted in a level two violation (a	01760		

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01760	Continued From page 43 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: R6's Service Plan dated September 3, 2021, indicated R6 received services to include, but were not limited to, medication management. R6's prescriber orders dated October 13, 2021, included, but were not limited to, capsaicin cream 0.75%-apply to affected area on left chest wall three times per day for two weeks. On November 3, 2021, at approximately 10:28 a.m. R6 was seated in the common area. Unlicensed personnel (ULP)-B approached R6 and announced that she was going to "put her cream on." With gloves on, ULP-B squeezed the cream from a tube, onto her own hand, pulled open R6's blouse around her neck, reached in and applied the cream to the left side of R6's upper chest. R6's Medication Sheet for the month of October, 2021, indicated capsaicin cream 0.75% was directed to apply topically to left chest wall three times daily, at 9:00 a.m., 2:00 p.m., and 8:00 p.m., for 14 days. Documentation indicated the cream was first administered on October 14, 2021, at 8:00 p.m. Although the prescriber's order was to apply the cream for 14 days, staff continued to apply the cream on November 3, 2021, or 21 days after first administering.	01760		

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01760	Continued From page 44 On November 3, 2021, at approximately 10:42 a.m. registered nurse (RN)-B verified medications should be given as prescribed. The licensee's Medication or Physician Orders-Implementation of -AL policy reviewed August 2021, indicated the RN was responsible for receiving medication prescriptions for residents receiving medication management, and medications are to be administered as prescribed. 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 medications were secure and permitted only authorized personnel access, for one of three medication storage areas (House #3) 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	01880		

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01880	Continued From page 45 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 held an assisted living with dementia care license and was licensed for a bed capacity of 33 residents, with three separate buildings connected by hallways. Each building had a locked medication room with a locked medication cart. On November 3, 2021, at approximately 9:45 a.m. the medication room door in House #3 was unlocked and wide open, with no staff members within view, and two male residents in wheelchairs sitting in front of the unlocked medication room. On November 3, 2021, at approximately 9:57 a.m. unlicensed personnel (ULP)-A stated the medication room door should always be closed and locked when staff weren't in there. On November 3, 2021, at approximately 10:42 a.m. registered nurse (RN)-B stated the medication carts should always be locked and the doors to the medication rooms should always be shut and locked when staff were not in the room. RN-B stated she was always reminding staff about this. On November 3, 2021, at approximately 12:02 p.m. the door to the medication room in House #3 was open, and the medication cart was unlocked. No staff were in view. Within two minutes, an unidentified male staff walked by and pushed the door shut; however, the medication cart remained	01880		

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01880	Continued From page 46 unlocked. On November 3, 2021, at approximately 12:20 p.m. ULP-C was in the medication room in House #3, and as she left the room, she pushed the door to close it, but it didn't latch and remained open. The medication cart was also observed to be unlocked. ULP-C went into the laundry room across the hall, and then left the area to take a basket of clothes to a resident's room. There were no staff in view. Approximately two minutes later, ULP-A entered the medication room and opened the medication cart without needing to unlock it. On November 4, 2021, at approximately 10:31 a.m. ULP-E unlocked the medication room in House #3 and entered. The medication cart was observed to be unlocked. On November 4, 2021, at approximately 3:50 p.m. the director of clinical services and RN-A indicated medication carts and medications rooms needed to be locked when not in use, and were working on a plan to ensure this. The licensee's Medication Administration-AL policy revised April 29, 2021, indicated "Medication carts are to be locked when not in direct view of the licensed nurse ULP responsible for the cart at the time." Also included, "Medication room doors are to remain closed and locked when not in use." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01890	Continued From page 47	01890		
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 with time sensitive dates were not expired, for one of one resident (R10) reviewed, during observation of medication storage. 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 November 4, 2021, at approximately 10:31 a.m. observation of the medication cart in House #3 with unlicensed personnel (ULP)-E, revealed eye drops for R10 with a label, which indicated the solution had been opened on September 27, 2021. On November 4, 2021, at approximately 10:35 a.m. ULP-E stated she didn't know how long the eye drops could be used, once opened, and	01890		

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01890	Continued From page 48 stated she thought maybe it was 30 or 60 days. R10's prescriber orders dated January 12, 2021, included timolol maleate solution 0.5% opthalmic drops- instill one drop in left eye every day for glaucoma. On November 4, 2021, at 12:19 p.m. registered nurse (RN)-A stated her expectation was, once a month during cycle exchange, nurses should go through the carts to check expiration dates. RN-A stated, "Nurses should be on top of that," and indicated a list should be posted in the medication rooms that directs when medications with accelerated expiration dates, should be disposed of. The manufacturer's instructions for use of timolol maleate 0.5% opthalmic solution dated June 16, 2013, directed for the solution to be used within four weeks after the bottle had been opened. The licensee's Medication Administration-AL policy revised April 29, 2021, included, "Discard date stickers are applied to vials, inhalers, eye drops indicating the date that the item is to be discarded." Also included, "Expired or discontinued medications will be promptly removed from the medication cart and disposed of per medication disposition policy." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 49 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content and failed to include the treatment in the service plan for one of two residents (R3) with records reviewed.	01940		

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01940	Continued From page 50 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: During the entrance conference on November 2, 2021, at approximately 11:32 a.m. registered nurse (RN)-A stated the licensee provided treatment management services to residents, including, but not limited to, blood glucose checks, compression stockings, and modified diets. R3's record lacked a treatment management plan to include the following required content: - a statement of the type of service that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R3's Service Plan dated July 7, 2021, indicated	01940		

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01940	Continued From page 51 R3 received services that included assistance with activities of daily living, escort/invite to meals, cueing with mobility, toileting, behaviors with verbal re-direction, and medication administration. The service plan did not include any therapy or treatment management. On November 3, 2021, at 3:58 p.m. R3 stated he didn't need much help from the staff, but was having trouble with swelling in his legs, and did need help with "these socks." R3 pulled up his pant leg to show he was wearing compression stockings. R3's prescriber orders dated October 13, 2021, included, "Knee-high TED [type of compression stocking] hose on in AM [morning] off @ [at] HS [bedtime] dx [diagnosis] edema [swelling]." R3's Medication Sheet for October 2021, indicated R3 began wearing the compression stockings on October 16, 2021, and documentation included staff initials to indicate the compression stockings had been applied each morning and removed each evening. On November 4, 2021, at approximately 3:53 p.m. RN-A verified a treatment management plan with the required content had not been developed for R3. The licensee's Development of the Individualized Treatment or Therapy Management Plan-AL policy revised August 1, 2021, directed for each resident receiving prescribed treatment or therapy orders, the RN would develop an individualized treatment management plan for the resident, in accordance with physician orders and in conjunction with the resident and/or the resident's representative, and would address the following:	01940		

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01940	Continued From page 52 - identification of the treatment or therapy management services to be provided by the facility; - identification of any specific resident instructions regarding the treatments or therapy the facility would administer; - identification of the staff who were responsible for the treatment or therapy management tasks, including tasks delegated to unlicensed staff; - procedure for staff to notify the licensed nurse when there was a problem with any treatments or therapy management service; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940		
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.	01960		

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01960	Continued From page 53 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed, or to document the reason they were not administered, and any follow up procedures that were provided to meet the resident's needs, for one of one resident (R1) receiving blood glucose monitoring 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 failed to ensure the registered nurse (RN) was notified of R1's high blood glucose levels, as ordered. R1's diagnoses included, but were not limited to, dementia, type 2 diabetes, and anxiety. R1's Service Plan dated March 26, 2021, indicated the resident received blood glucose monitoring before breakfast, daily. R1's prescriber orders dated August 3, 2021, included an order for fasting (before eating) blood glucose testing, to be completed every morning, and directed to call nurse if blood glucose was less that 100 or over 350. In addition, the order directed the nurse to call the medical doctor (MD)/nurse practioner (NP).	01960		

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01960	Continued From page 54 On November 4, 2021, at approximately 8:15 a.m. unlicensed personnel (ULP)-A was observed to conduct a blood glucose check for R1, which resulted in a reading of 217 milligrams (mg)/deciliter (dL). R1's Medication Sheet dated October 2021, indicated blood glucose levels were completed daily. The following dates resulted in a blood glucose level over 350: - October 8, 2021, blood glucose result of 352 mg/dL - October 10, 2021, blood glucose result of 435 mg/dL - October 12, 2021, blood glucose result of 425 mg/dL - October 13, 2021, blood glucose result of 421 mg/dL - October 14, 2021, blood glucose result of 352 mg/dL - October 15, 2021, blood glucose result of 402 mg/dL - October 24, 2021, blood glucose result of 369 mg/dL - October 29, 2021, blood glucose result of "HI" R1's record lacked evidence that the RN had been notified of the above noted blood glucose results which had been greater than 350 mg/dL, as ordered by the prescriber, and lacked evidence the MD/NP were notified. On November 3, 2021, at approximately 2:41 p.m. RN-B confirmed there was no evidence of documentation an RN had been notified of R1's elevated blood glucose results noted above as directed by the prescriber, and stated she didn't recall being notified by the ULP of the blood glucose levels that were out of the range directed	01960		

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01960	Continued From page 55 by the prescriber. The licensee's Blood Glucose Monitoring-AL policy dated December 18, 2019, indicated ULP would notify nurse of blood glucose that was out of range for the resident or per individual physician orders, and the nurse would notify the physician of out of range blood glucose levels as indicated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
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. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to provide hazard vulnerability assessment or safety risk, as required by MN Statute 144G.81 Subd.1 (a). This had the potential to affect all current residents, staff and visitors.	02040		

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02040	Continued From page 56 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 November 2, 2021, between 11:50 a.m. and 12:15p.m. an interview and record review was conducted with the Health Support Specialist (HSS) on the facility hazard vulnerability assessment. The licensee did not have a record or a policy on a hazard vulnerability assessment or safety risk for the property. The HSS indicated the licensee held monthly safety meetings to discuss hazards in the facility that arise and how to deal with them, but do not formally document these hazards or put them into a hazard vulnerability assessment of the property. An "Emerald Crest Shakopee Hazards Risk Assessment" was provided by email after the survey. A review of this plan showed only possible risks to the property, but did not prescribe the mitigation standards for the risks identified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02160 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required	02160		

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02160	Continued From page 57 in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and (4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure dementia cares services provided to residents that promoted dignity for two of two residents (R7, R8) 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).	02160		

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02160	Continued From page 58 The findings include: R7 R7's diagnoses included, but were not limited to, cognitive impairment, hearing impairment, and hypertension. R7's Service Plan dated May 4, 2021, indicated R7's services included, but were not limited to, assistance with grooming that included laying out grooming supplies needed (toothbrush, toothpaste, deodorant, hairbrush, etc.) and checking-in for quality completion. R7's Resident History dated May 11, 2021, indicated R7 "cares about her hair, likes it curled." It also indicated R7 wanted to be social and wanted to put make-up on. On November 3, 2021, at approximately 8:30 a.m. R7 walked out of her room using her walker, accompanied by unlicensed personnel (ULP)-A and ULP-B. R7 stopped several times, stating "I need to comb my hair first. Stop. I need to comb my hair." ULP-B encouraged R7 to keep walking to the dining room for breakfast. R7 stopped, and again stated, "Comb my hair first." ULP-B stated she would look in the main bathroom for resident's brush, but wanted resident to walk to dining room first. R7 insisted she needed to comb her hair first. ULP-B went into another resident's room, brought out a hairbrush, and brushed R7's hair. R7 ambulated toward the dining room, and ULP-A asked her, "Why are you so grumpy today?" R7 glared at ULP-A, and ambulated to the dining room, mumbling. R8 R8's diagnoses included, but was not limited to,	02160		

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02160	Continued From page 59 dementia. R8's Service Plan dated February 25, 2021, indicated R8's services included, but were not limited to, assistance with dressing, grooming, bathing, transfers with assistance of two staff, toileting, medication management, and behaviors, indicating he was verbally disruptive to self, others, environment, and was resistive to cares, and required verbal re-direction each shift. On November 3, 2021, at approximately 11:35 a.m. R8 was observed in his wheelchair, in the kitchen area, and ULP-A was pushing him out of the kitchen and stated, "You can't be in the kitchen." R8 appeared angry and hollered, "stupid ass!" ULP-A answered, "You can't be in the kitchen." R8 hollered, "stupid ass!" This continued, back and forth, several times. R8 eventually self-propelled his wheelchair away from the kitchen, swearing under his breath. On November 4, 2021, at approximately 3:50 p.m. the director of clinical services and registered nurse (RN)-A verified the above observations did not promote dignity for R7 and R8. The licensee's Resident Dignity, Choices, and Preferences policy reviewed February 25, 2020, indicated upon hire all staff would be educated on resident rights, accommodation of need, and the customer service protocols of the facility. It also included, it was the daily expectation that all staff treat residents with kindness, dignity, and respect while providing care and in all other interactions. No further information was provided. TIME PERIOD FOR CORRECTION:	02160		

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02160	Continued From page 60 Twenty-One (21) days	02160		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of one resident (R6) observed during medication administration. This practice resulted in a level two violation (a	02410		

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02410	Continued From page 61 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: R6's prescriber orders dated October 13, 2021, included, but was not limited to, capsaicin cream (treats arthritic pain) 0.75% - apply to affected area on left chest wall three times per day for two weeks. On November 3, 2021, at approximately 10:28 a.m. R6 was seated in the common area with other residents and a resident's visitor. Unlicensed personnel (ULP)-B approached R6 and announced that she was going to "put her cream on." With gloves on, ULP-B squeezed the cream from a tube, onto her own hand, pulled open R6's blouse around her neck, reached in and applied the cream to the left side of R6's upper chest. When interviewed at this time, ULP-B stated it was okay to apply the cream in the common area, as long as she didn't expose the resident's chest. On November 3, 2021, at approximately 10:47 a.m. registered nurse (RN)-B stated it was never okay to apply creams in the common area. RN-B stated residents should be taken to their rooms for procedures, to ensure their privacy. The licensee's Resident Dignity, Choices, and Preferences policy reviewed February 25, 2020, directed staff would treat residents with dignity	02410		

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02410	Continued From page 62 and respect at all times while providing care and in all other interactions. A policy regarding privacy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has	03000		

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03000	Continued From page 63 been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to immediately report an incident to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R3) who did not return to the facility, after being allowed to leave the facility against the family's wishes, 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	03000		

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03000	Continued From page 64 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 2, 2021, at approximately 11:45 a.m. a request was made to the director of clinical services, registered nurse (RN)-A, and the regional director of operations to review all vulnerable adult reports the licensee had made to MAARC in the past six months, to which they indicated no MAARC reports had been submitted. On November 3, 2021, at approximately 9:45 a.m. R3 was observed in the dining room, sitting with a male and a female resident, taking his medications from a plastic cup and putting them in his mouth. R3 was admitted to the facility on July 22, 2021, with diagnoses which included, but were not limited to, depression, alcohol abuse, and dementia. R3's Service Plan dated July 7, 2021, indicated R3 received services that included assistance with activities of daily living, escort/invite to meals, cueing with mobility, toileting, behaviors with verbal re-direction, and medication management. R3's Assessment for Client Vulnerability, Safety, and Risk to Others dated October 31, 2021, indicated R3 had behaviors posing a risk to himself, and "Due to past history of alcoholism and others taking financial advantage of resident he needs a secured environment due to poor judgement for his own safety/security. Keep resident engaged in daily activities to keep him busy. Allow him to socialize with others during mealtime and activities. Report any concerns to	03000		

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03000	Continued From page 65 nursing/OT [occupational therapy]." R3's progress notes indicated on September 17, 2021, at 4:02 p.m. R3 became agitated when he asked a staff member to give him a ride to the dry cleaners and she left at the end of her shift without taking him. R3's daughter and power of attorney (POA), was contacted and directed R3 was not to go anywhere with anyone other than family. On September 20, 2021, at 2:38 p.m. R3 was requesting to go to the bank and wanted to give money to a friend. R3's POA was contacted and gave permission for him to go out with his friend, as long as she picked him up, and stated R3 had limited access to his money. R3 signed out and left the facility at 3:20 p.m. with a female. At 8:00 p.m., R3 had not returned to the facility and staff contacted R3's POA, whom stated she would locate him by cell phone. At 9:20 p.m., R3 returned to the facility smelled of alcohol, and admitted to the staff that he had been drinking at the Legion. R3 was very loud, yelling, and verbally abusive toward staff upon his return. On September 21, 2021, at 11:28 a.m. R3's POA was updated, stated she did not know the female friend that picked him up, and again stated R3 was not to go out with anyone but family. On September 25, 2021, at 8:09 p.m. R3 left the facility with the same female friend because the unlicensed personnel (ULP) on duty was not aware that R3 was not allowed to leave the facility except with family. Registered nurse (RN)-B attempted to locate R3 at places he had frequented in the past, and the police were notified.	03000		

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03000	Continued From page 66 On September 26, 2021, at 12:00 a.m. a police officer called RN-B, and stated the female friend had been contacted, and she reported leaving R3 at the Legion. The police officer went to that location and R3 was not there, so went to the Veterans of Foreign War (VFW) a block away, and spotted R3 walking on the sidewalk in front of the VFW. RN-B was able to get R3 into the car to go back to the facility. R3 smelled of alcohol and cigarette smoke, and had an unsteady gait. R3's POA was notified R3 was located and returned to the facility, and was okay. On November 4, 2021, at approximately 3:29 p.m. director of clinical services and RN-A stated no MAARC report was filed when R3 left the facility, could not be located, and did not return until he was located by the police, and stated staff would be reeducated. The licensee's Abuse Prohibition-AL-MN policy reviewed June 4, 2021, indicated each employee is responsible to immediately report all alleged violations and substantiated incidents involving vulnerable adults, to the state agency, orally or online, to MAARC, and all other agencies as required. The licensee's Missing Resident Plan revised October 21, 2021, indicated the Department of Health or the designated State Agency for reporting of a missing vulnerable adult (VA) would be notified and a complete initial report would be filed per state and federal regulations. Also included, appropriate final VA report or notification of the State Agency would be provided, as required. No further information was provided.	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21389	A. BUILDING: _____ B. WING _____	11/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF SHAKOPEE	**1855 10TH AVENUE WEST SHAKOPEE, MN 55379**

(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
03000	Continued From page 67 TIME PERIOD FOR CORRECTION: Seven (7) days	03000		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *11/02/21*
Time: 11:48:00
Report: 1024211304

Food and Beverage Establishment Inspection Report

Location:
Emerald Crest Of Shakopee
1855 10th Avenue West
Shakopee, MN55379
Scott County, 70

Establishment Info:
ID #: 0039272
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522338811
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT TO MEASURE QUATERNARY AMMONIUM (Q.A.). PROVIDE AND MAINTAIN.

Comply By: 11/09/21

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

ONLY SERVSAFE CERTIFICATE WAS POSTED. CFPM WAS VERIFIED VIA CFPM ONLINE PORTAL.

Comply By: 03/02/22

4-100 Equipment Construction Materials

4-101.19

MN Rule 4626.0495 Remove non-food-contact surfaces of equipment that are exposed to splash, spillage, or other food soiling, or that require frequent cleaning, that are not constructed of a corrosion-resistant, non-absorbent, and smooth material.

COUNTERS AND CABINETS IN KITCHENETTES 1 AND 2 ARE LAMINATE OVER COMPOSITE WOOD. COUNTERS SHOW SIGNS OF DAMAGE. IN THE EVENT OF A REMODEL OR SIGNS OF DAMAGE, THESE SHOULD BE REPLACED WITH A NON-ABSORBENT, SMOOTH MATERIAL.

Comply By: 05/02/22

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

SEALS ALONG COUNTERS AND WALL BEGINNING TO FAIL IN KITCHENETTES 1 AND 2. REMOVE SEALS, CLEAN THOROUGHLY AND REPLACE WITH A FOOD GRADE SEALANT.

Comply By: 11/09/21

Surface and Equipment Sanitizers

Utensil Surface Temp: = 163 at Degrees Fahrenheit
Location: MAIN KITCHEN DISHWASHING MACHINE
Violation Issued: No

Utensil Surface Temp: = 168 at Degrees Fahrenheit
Location: KITCHENETTE 1 DISHWASHING MACHINE
Violation Issued: No

Utensil Surface Temp: = 173 at Degrees Fahrenheit
Location: KITCHENETTE 2 DISHWASHING MACHINE
Violation Issued: No

Quaternary Ammonium: = 400+ PPM at Degrees Fahrenheit
Location: QUATERNARY AMMONIUM DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/CUT MELON
Temperature: 40 Degrees Fahrenheit - Location: ARTIC AIR STAND UP COOLER - MAIN KITCHEN
Violation Issued: No

Process/Item: Cold Holding/CUT MELON
Temperature: 41 Degrees Fahrenheit - Location: ARTIC AIR STAND UP COOLER - KITCHENETTE 1
Violation Issued: No

Process/Item: Cold Holding/DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: ARTIC AIR STAND UP COOLER - KITCHENETTE 1
Violation Issued: No

Process/Item: Cold Holding/CUT MELON
Temperature: 41 Degrees Fahrenheit - Location: ARTIC AIR STAND UP COOLER - KITCHENETTE 2
Violation Issued: No

Process/Item: Cold Holding/HAMB.CASSER.
Temperature: 40 Degrees Fahrenheit - Location: ARTIC AIR STAND UP COOLER - KITCHENETTE 2
Violation Issued: No

Type: Full
Date: *11/02/21*
Time: 11:48:00
Report: 1024211304
Emerald Crest Of Shakopee

Food and Beverage Establishment Inspection Report

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

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- REPORTABLE DISEASES.
- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY.
- DATE MARKING: USING PASTEURIZED EGGS.
- PROPER SANITIZING LEVELS FOR QUATERNARY AMMONIUM AND CHLORINE.

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 1024211304 of 11/02/21.

Certified Food Protection Manager: VICTORIA SUDUE TAYLOR

Certification Number: FM99998 Expires: 02/05/22

Signed: _____
VICKY TAYLOR
CARETAKER

Signed: _____
Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us