Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 29, 2024

Licensee
Elmhurst Commons Apartments
400 3rd Street Southwest
Braham, MN 55006

RE: Project Number(s) SL30591015

Dear Licensee:

On July 30, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 2, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Electronically Delivered

May 29, 2024

Licensee
Elmhurst Commons Apartments
400 3rd Street Southwest
Braham, MN 55006

RE: Project Number(s) SL30591015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 2, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30591	A. BUILDING: _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMHURST COMMONS APARTMENTS	400 3RD STREET SW BRAHAM, MN 55006

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30591015 On April 29, 2024 through May 2, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 28 residents receiving services under the provider's Assisted Living license. An immediate correction order was identified on May 1, 2024, for order 1750. On May 2, 2024, at 8:51 a.m., the immediacy of the order was lifted, however, scope and level remain the same.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated Monday, April 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 2 program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, 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) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees (unlicensed personnel (ULP)-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	0 660		

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0 660	Continued From page 3 The findings include: During the entrance conference on April 29, 2024, at 10:48 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated TB history screen and baseline TST screenings were completed at employee hire. The facility's TB risk assessment was completed on July 19, 2023, and the facility was determined to be a low risk level. ULP-E ULP-E was hired on January 17, 2024, to provide direct care services to the licensee's residents. On April 29, 2024, at 2:38 p.m., the surveyor observed ULP-E prepare and administer R4's scheduled afternoon medications. ULP-E's employee record included a baseline TB screening for active TB and documentation of a negative TST on January 19, 2024; however, lacked evidence a second step TST had been completed. ULP-F ULP-F was hired October 13, 2016, to provide direct care services to the licensee's residents. On April 30, 2024, at 7:06 a.m., the surveyor observed ULP-F prepare and administer R6's scheduled morning medications. ULP-F's employee record included a baseline TB screening for active TB and documentation of a negative TST on October 20, 2016; however, lacked a second step TST had been completed. On April 30, 2024, at 1:58 p.m., LALD/LPN-A	0 660		

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0 660	Continued From page 4 confirmed ULP-F's record lacked evidence a second step Mantoux had been completed. LALD/LPN-A stated ULP-E received a first step TST on January 16, 2024, and had a year to complete the second step TST since the provider's TB risk assessment indicated the facility was to be a low risk level. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated new staff would have an IGRA (serum blood test) or a two-stop Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs (health care workers). Staff TB screening results would be kept in each employee medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, 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 should be performed withing one to three weeks of a negative first step TST. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 5 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on May 1, 2024, at 9:45 a.m., with housing manager (HM)-G, the surveyor made the following observations of facility hazards and disrepair: The exhaust fan was missing, and loose wires were present in the fan housing on the ceiling in the trash room near resident room 207. The door closer was removed from the fire-resistant rated door of the storage room near	0 800		

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0 800	Continued From page 6 resident room 217. Fire-resistant rated doors are required to be maintained as designed and installed at the time of construction approval. The light fixture cover was missing from the light fixture in the corridor near resident rooms 217 and 211. The clothes dryer front cover was removed exposing sharp metal edges in the open laundry room near resident room 117. There was water damage on the ceiling and the floor covering was removed in the room labeled as exercise room on the main floor. There was also water staining in the corridor in the same area due to a leak on the level above. During the tour HM-G, stated the water damage was from the furnace above this area, the leak has been repaired but the ceiling and floor have not yet been repaired. The exit signs did not work when tested in the dining room, in the corridor near resident room 114 and in several other locations throughout the facility. The emergency light did not work when tested in the corridor near resident room 110. An extension cord was observed strapped to the wall and used as permanent wiring for power to the refrigerator/ freezer in the food storage room. The door did not automatically close and latch because it was out of adjustment on the fire-resistant rated door of the trash room near resident room 107. The wood support pillars were in need of paint for	0 800		

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0 800	Continued From page 7 protection from the elements at the front entrance canopy. The main front exterior door and exterior exit door leading out of the building on the end facing the garages are rusting out and damaged at the bottom. During a facility tour on May 1, 2024, at 11:30, HM-G, verified the above listed observations while accompanying on the tour and stated they understand the findings require repair. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810		

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0 810	Continued From page 8 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 1, 2024, at 9:15 a.m., housing manager (HM)-G, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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0 810	Continued From page 9 TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire at least twice per year as evident by providing documentation training was provided to employees at onboarding, but no documentation was provided the training was provided twice a year thereafter. During an interview on May 1, 2024, at 9:45 a.m., HM-G, stated they were not in full understanding of the training requirement but now understand the requirement to train employees and document the training at hire and twice per year after. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date	01060		

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01060	Continued From page 10 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1) reviewed for a hospitalization. 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	01060		

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01060	Continued From page 11 resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included multiple sclerosis, anxiety, chronic congested heart failure, and mild cognitive impairment. R1's record indicated on December 30, 2023, R1 went into the hospital. R1's progress note indicated R1 returned to the facility from the hospital and transitional care unit (TCU) on January 18, 2023, R4 was admitted to the hospital. On November 3, 2023, R4's progress note indicated R4 was discharged from the hospital and admitted to a short-term rehabilitation facility. R1's record included a written notice that lacked the following content: - contact information for the OOLTC and the Office of Ombudsman for Mental Health and Developmental Disabilities. In addition, R1's record did not include notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days as required. On April 29, 2024, at 3:48 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A confirmed the written notice of emergency relocation lacked the required content noted above and stated she recently learned notification to the ombudsman was required for a hospital stay of four days or greater.	01060		

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01060	Continued From page 12 The licensee's Emergency Relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, the licensee would provide a written notice which would include: the reason for the relocation; the name and contact information for the location to which the resident has been relocated and any new service provider, contact information for the OOLTC, if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; and if the facility refuses to provide housing or services after relocation, the resident has the right to appeal and who to contact to proceed with the appeal. If the resident has not returned to the facility within four days, the Ombudsman would be notified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under	01290		

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01290	Continued From page 13 this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of two employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-F was hired October 13, 2016, to provide direct care services to the licensee's residents. On April 30, 2024, at 7:06 a.m., the surveyor observed ULP-F administering R6's scheduled morning medications. ULP-F's employee record included a BGS clearance affiliated with the licensee's former and closed comprehensive HFID license 28288. ULP-F's employee record lacked evidence of a BGS was completed with the licensee's assisted living HFID license 30591.	01290		

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01290	Continued From page 14 On May 2, 2024, at 12:35 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULP-F had a BGS clearance under their old comprehensive license when ULP-F started employment and was unaware ULP-F's BGS needed to be submitted under the new licensee's assisted living license. The licensee's Background Studies policy dated August 1, 2021, indicated a licensee's employee may not provide direct services to residents until acceptable results of BGS have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls;	01370		

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01370	Continued From page 15 (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01370		

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01370	Continued From page 16 ULP-E was hired February 3, 2023, to provide direct care services to the licensee's residents. On April 29, 2024, at 2:38 p.m., the surveyor observed ULP-E administering R4's scheduled afternoon medications. ULP-E's employee record lacked evidence ULP-E had received the following required training and/or competencies: -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting. On April 30, 2024, at 1:58 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULPs training did not include competency evaluations for personal hygiene and grooming and was unaware of the requirement. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated prior to delegation of services the licensee must make certain the ULPs are trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. Training and competency evaluation for the ULPs would include: -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting. No further information was provided.	01370		

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01370	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 18 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's diagnoses included chronic obstructive pulmonary disease (COPD-difficulty breathing), and diabetes. On April 30, 2024, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-F observe R2 check her own blood glucose with the Libre monitor and record R2's blood glucose results of 215 mg/dl (milligrams per deciliter). R2's prescriber orders dated February 26, 2024, included blood glucose monitoring four times a day and to assist R2 with management of oxygen daily as needed. R2's May 2024 Services Delivered record, indicated R2 received blood glucose monitoring four times a day and oxygen maintenance services daily. R2's Service Plan dated May 1, 2023, did not include R2 received the following services: -blood glucose monitoring four times a day; and -oxygen maintenance daily. On April 30, 2024, at 9:40 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated service plans were updated with changes in resident services. LALD/LPN-A stated R2's service plan in R2's record had not	01640		

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01640	Continued From page 19 been updated since May 2023, to reflect current services to include blood glucose and oxygen monitoring. LALD/LPN-A stated R2's service plan had been updated in the computer and was going to have R2 review and sign during R2's annual review in next month (May 2024). LALD/LPN-A stated R2's service plan should have been updated when R2's blood glucose and oxygen monitoring services were added. The licensee's Service Plan Modifications policy, date August 1, 2021, indicated when a resident at the licensee's facility receives assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for	01700		

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01700	Continued From page 20 medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents were assessed for self-administration of medications for two of two residents (R2, R3) who self-administered insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnosis included diabetes type II. R2's Service Plan dated May 1, 2023, indicated	01700		

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01700	Continued From page 21 R2 received medication assistance services. R2's prescriber orders dated December 7, 2023, included Basaglar (long-acting) insulin 28 units daily. R2's prescriber orders dated February 15, 2024, included Fiasp (fast-acting) insulin 32 units three times a day with meals. R2's 90-Day review dated April 23, 2024, indicated R2 required assistance with medication administration including oral medication, inhalers, and staff were to verify insulin dose. R2's record did not include an assessment to determine R2 was able to prepare and self-administer insulin safely and appropriately. On April 30, 2023, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-F hand R2 her Basaglar and Fiasp insulin pens to prepare and self-administer. ULP-F observed R2 dial Basaglar insulin pen to 28 units and dial Fiasp insulin pen to 32 units and self-administer insulin's into left lower abdomen. R2 did not prime insulin pens two units prior to dialing prescribed dose and administer. R3 R3's diagnoses included diabetes type II. R3's Service Plan dated January 1, 2023, indicated R3 received medication assistance services. R3's prescriber orders dated July 19, 2023, included Humalog (fast-acting insulin) three times a day and to prime two units of insulin prior to dialing six units of insulin to administer before each meal.	01700		

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01700	Continued From page 22 R3's 90-Day review dated April 17, 2024, indicated R3 required assistance with medications. R3's record did not include an assessment to determine R3 was able to prepare and self-administer insulin safely and appropriately. On April 30, 2024, at 11:21 a.m., the surveyor observed ULP-F hand R3 her Humalog insulin pen, R3 dialed three units of insulin and self-administered into right arm. R3 did not prime insulin pen two units prior to dialing prescribed dose to administer. On April 30, 2024, at 1:49 p.m., ULP-F and ULP-H stated residents were independent with insulin administration and staff do not administer insulin, only verify insulin dose before the residents administered. ULP-F stated the nurses assess the residents to determine if they are able to self-administer own medications. On April 30, 2024, at 1:58 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated residents were assessed by the registered nurse (RN) to be able to self-administer own insulin, eye drops, inhalers, and nebulizers. LALD/LPN-A stated she was unaware R2 and R3 were not assessed to self-administer insulin. On May 1, 2024, at 1:13 p.m., during a telephone interview, RN-C stated she started working for the licensee March 2023, and was hired part-time and primarily completed resident assessments. RN-C stated she had not completed any self-medication assessments for residents since she started employment and did not address in residents 90-day assessments. RN-C stated the	01700		

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01700	Continued From page 23 licensee only had one or two new admissions since she started, and the new residents did not self-administer any medications. On May 1, 2024, at 11:07 a.m., clinical nurse supervisor (CNS)-B stated RN-C completed the licensee's resident assessments. CNS-B stated at admission and as needed residents were assessed for the ability to self-administer medications including insulin. The licensee's Medication Management policy dated August 1, 2021, indicted the licensee would, prior to providing medication management services, have the registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services would be provided and how the services would be provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and	01750		

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01750	Continued From page 24 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) instructed the unlicensed personnel (ULP) in the proper methods to administer medications, and the unlicensed personnel had demonstrated the ability to competently follow the procedures for administering medications. This had the potential to affect all 28 residents receiving assisted living services. 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). This practice resulted in an immediate correction order on May 1, 2024, at approximately 3:15 p.m. The findings include: On April 29, 2024, at 10:48 a.m., during entrance conference, licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee employed a part-time RN who completed resident assessments and clinical nurse supervisor (CNS)-B was the regional CNS who had oversight of the facility. LALD/LPN-A stated she was responsible for new staff training and completing staff competency evaluations.	01750		

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01750	Continued From page 25 LALD/LPN-A stated after being trained by CNS-B, LALD/LPN-A was delegated staff training responsibilities including completing skill competency evaluations for medication administration. ULP-E was hired January 17, 2024, to provide direct care services to residents of the assisted living facility. ULP-E's training record indicated ULP-E completed medication administration training through Educare (online training) October 7, 2023, prior to employment. ULP-E's record indicated ULP-E completed medication skill competency conducted by LALD/LPN-A on January 17, 2024. ULP-E's record lacked evidence ULP-E demonstrated competency by the registered nurse (RN) in medication administration. On April 29, 2024, at 2:38 p.m., the surveyor observed ULP-E prepare and administer R4's scheduled afternoon medications. Immediately following the medication observation, ULP-E stated she was trained and had to demonstrate competency in medication administration to LALD/LPN-A before she could administer medications. On May 1, 2024, at 11:07 a.m., during a telephone interview, CNS-B stated she was responsible for the oversight of [licensee]. CNS-B stated she trained and delegated staff training and competency skills evaluations to LALD/LPN-A under CNS-B's supervision. CNS-B stated she was educated to believe if the RN trained the LPN on staff training and used the correct forms, the RN could delegate staff training and competency evaluations to the LPN. CNS-B	01750		

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01750	Continued From page 26 stated she was not aware the RN could not delegate staff training and competency evaluations to the LPN. The licensee's Medication and Treatment-Administration and Delegation policy dated August 1, 2021, indicated when administration of medications or treatment/therapy was delegated or assigned to unlicensed personnel, the licensee would ensure the registered nurse instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP had demonstrated the ability to competently follow the procedures. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated training and competency evaluations of ULPs would be conducted by a RN, or another instructor may provide the training in conjunction with a RN. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by survey supervisor review on May 2, 2024, however noncompliance remains at a scope and level of two, widespread (F).	01750		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who	01760		

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	30591	A. BUILDING: _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMHURST COMMONS APARTMENTS	400 3RD STREET SW BRAHAM, MN 55006

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01760	Continued From page 27 administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per the manufacturer's instructions for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnosis included diabetes type II. R2's Service Plan dated May 1, 2023, indicated R2 received medication assistance services. R2's prescriber orders dated December 7, 2023, included Basaglar (long-acting) insulin 28 units daily. R2's prescriber orders dated February 15,	01760		

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01760	Continued From page 28 2024, included Fiasp (fast-acting) insulin 32 units three times a day with meals. On April 30, 2023, at 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-F hand R2 her Basaglar and Fiasp insulin pens to prepare and self-administer. ULP-F observed R2 dial Basaglar insulin pen to 28 units and dial Fiasp insulin pen to 32 units and self-administer insulin's into left lower abdomen. R3 did not prime insulin pens two units prior to dialing prescribed dose and ULP-F did not remind R2 to prime each insulin pen prior to dialing insulin doses before self-administering. R3 R3's diagnoses included diabetes type II. R3's Service Plan dated January 1, 2023, indicated R3 received medication assistance services. R3's prescriber orders dated July 19, 2023, included Humalog (fast-acting insulin) three times a day and to prime two units of insulin prior to dialing six units of insulin to administer before each meal. On April 30, 2024, at 11:21 a.m., the surveyor observed ULP-F hand R3 her Humalog insulin pen, R3 dialed three units of insulin and self-administered into right arm. R3 did not prime insulin pen two units prior to dialing prescribed dose and administer. ULP-F observed R3 prepare insulin and self-administer and did not remind R3 to prime insulin pen before dialing prescribed dose. On April 30, 2024, at 12:41 p.m., licensed assisted living director/licensed practical nurse	01760		

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01760	Continued From page 29 (LALD/LPN)-A stated residents were responsible to prepare and self-administer own insulin and ULPs were only to verify the dose of insulin after the resident dialed insulin dose. LALD/LPN-A stated it was the residents choice whether to prime the insulin pens two units prior to dialing insulin dosage. On April 30, 2024, at 1:13 p.m., during a telephone interview, registered nurse (RN)-C stated she was unaware residents were not priming insulin pens two units prior to dialing prescribed dose and staff were not reminding residents. RN-C stated if she was made aware, she would educate the resident the importance of priming insulin pens was to ensure they are receiving the correct amount of insulin. On April 30, 2024, at 1:49 p.m., ULP-F and ULP-H stated residents were independent with insulin administration and staff were to verify correct dosage of insulin before the residents administered. ULP-F stated ULPs could give reminders to prime the insulin pen but it was ultimately the resident's choice. On May 1, 2024, at 11:07 a.m., during a telephone interview, clinical nurse supervisor (CNS)-B stated ULPs have been trained insulin pens should be primed two units prior to dialing insulin dose. CNS-B stated ULPs do not administer insulin and if a resident prepares own insulin, staff should give the residents reminders to prime insulin pen and if the resident declined, ULPs should notify the nurse so the nurse can provide education to the resident. The licensee's Injections and Finger Puncture policy dated August 1, 2021, directs to prime insulin pen by dialing pen to two units of insulin	01760		

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01760	Continued From page 30 and pushing button to release and assist resident in dialing pen to correct units of insulin per MAR (medication administration record) instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must	01790		

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01790	Continued From page 31 address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) developed written procedures with all the required content for unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available.	01790		

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01790	Continued From page 32 In addition, the licensee failed to ensure one of one ULP(-E) was trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-E was hired January 17, 2024, to provide direct care services to residents of the assisted living facility which include medication administration. On April 29, 2024, at 2:38 p.m., the surveyor observed ULP-E prepare and administer R4's scheduled afternoon medications. ULP-E's employee record lacked evidence to indicate ULP-E had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home. On April 30, 2024, at 2:38 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee had a policy for planned and unplanned time away; however, the licensee had not developed a written procedure for unplanned time away. LALD/LPN-A stated she trained staff on the unplanned time away procedure during orientation; however, does not	01790		

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01790	Continued From page 33 document training or competency. The licensee's Medication Management - Planned and Unplanned Time Away policy dated August 1, 2021, indicated the licensee providing medication management services to the resident and controls the resident's access to the medication the following procedures for giving accurate and current medications to clients for unplanned times away from home would be followed, according to the resident's individual medication management plan. For unplanned time away when a licensed nurse is not available, a pharmacist or licensed nurse was not available, the registered nurse may delegate this task to unlicensed personnel. The registered nurse would train the unlicensed staff and determine the unlicensed staff was competent to follow the procedures for giving medications to residents. The registered nurse would develop written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that were prescribed for the client. The written procedure must address: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to given to the client or client's representative; - how the unlicensed staff must document in the resident's record that medications have been given to the client or client's representative, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were	01790		

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01790	Continued From page 34 provided to the resident, and other required information; - how the RN shall be notified that medications have been given to the client or client's representative and whether the RN needs to be contacted before the medications are given to the client or the client's representative; -a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and -how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
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 securely stored and only authorized personnel had access to medication being stored by the licensee. This practice resulted in a level two violation (a	01880		

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01880	Continued From page 35 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 entrance conference on March 29, 2024, at 10:48 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated medications were stored in each resident's room and overstock medications were securely stored in the nurse's office. R5's diagnoses included chronic sinusitis (inflammation of the nasal passages). R5's prescriber orders dated July 20, 2023, included Flonase (used to treat allergy symptoms) 50 micrograms (mcg) two sprays in each nostril daily and on April 11, 2024, R5's Flonase nasal spray order was changed to as needed. On April 30, 2024, the surveyor observed R5's unopened Flonase nasal spray on the desk in the ULP's office, no staff present and the office door unlocked and propped open at 6:55 a.m., 8:10 a.m., and 9:23 a.m. On April 30, 2024, at 9:48 a.m., the survey observed with LALD/LPN-A R5's unopened nasal spray on the desk in the unlicensed personnel (ULP) office. The door of the office was unlocked and propped opened, and no staff were present. LALD/LPN-A stated the ULP office door was	01880		

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01880	Continued From page 36 unlocked during the day to allow agency staff from outside provides access to the room to complete their charting and the office door was locked during the night. LALD/LPN-A stated she had given the nasal spray to staff that morning to put in R5's room in her locked medication cabinet. The licensee's Medication Storage policy, dated August 1, 2021, indicated medications managed inside a resident's private "living space" must be securely locked and permit only authorized personnel to have access. This was a locked cabinet. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription labels and the date time sensitive medications with opened or expiration dates for one of two residents (R3).	01890		

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01890	Continued From page 37 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 R3's diagnoses included diabetes type II. R3's Service Plan dated January 1, 2023, indicated R3 received medication assistance services. R3's annual prescriber orders dated July 19, 2023, included Humalog (fast-acting insulin) three times a day and Lantus (long-acting) insulin twice a day. R3's 90-Day review dated April 17, 2024, indicated R3 required assistance with medications. R3's April and May's 2024, Medication Administration Records, indicted R3 received Humalog and Lantus insulin. On April 30, 2024, at 11:21 a.m., the surveyor observed unlicensed personnel (ULP)-F hand R3 her Humalog insulin pen, R3 dialed three units of insulin and self-administered into right arm. The surveyor observed and ULP-F confirmed R3's opened Humalog and two opened Lantus Solostar insulin pens stored in R3's room lacked the date the insulins had been opened and when	01890		

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01890	Continued From page 38 the insulins would expire. ULP-F stated insulins, eye drops and inhalers should be dated when opened. On May 2, 2024, at 12:23 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated insulin, eye drops, and inhalers should be dated when opened and staff have been trained on the procedure. LALD/LPN-A stated usually the pharmacy put a yellow date sticker on time sensitive medications for staff to add the date when the medication was opened. The manufacturer's instructions revised November 2019, indicated Humalog insulin must be discarded 28 days after opened even if it still contains insulin. The manufacturer's instructions revised June 2022, indicated Lantus insulin must be discarded 28 days after opened even if it still contains insulin. The licensee's Medication Storage policy dated indicated medications would be stored consistent with manufacture's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *04/29/24*
Time: 12:05:06
Report: 1029241140

Food and Beverage Establishment Inspection Report

Location:
Elmhurst Commons
400 3rd Street S.W.
Braham, MN55040
Isanti County, 30

Establishment Info:
ID #: 0013226
Risk: High
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:
Elmhurst Commons, LLC

Phone #: 6514280646
ID #: 22174

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

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
NO CFPM. EMPLOYEE CURRENTLY TRAINING TO BECOME CFPM. EMPLOY CFPM.
Comply By: 05/31/24

Surface and Equipment Sanitizers

CHLORINE: = 75 PPM at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

QUAT: = 400 PPM at Degrees Fahrenheit
Location: SANI DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: POTATOES AU GRATIN
Temperature: 149 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: MEATBALLS
Temperature: 146 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: MILK
Temperature: 38 Degrees Fahrenheit - Location: COLD HOLDING MAIN KITCHEN 2-DOOR
Violation Issued: No

Type: Full
Date: *04/29/24*
Time: 12:05:06
Report: 1029241140
Elmhurst Commons

Food and Beverage Establishment Inspection Report

Process/Item: SLICED TURKEY
Temperature: 40 Degrees Fahrenheit - Location: COLD HOLDING DOWNSTAIRS COOLER
Violation Issued: No

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

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 1029241140 of 04/29/24.

Certified Food Protection Manager: VACANT

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
ANGEL KAHLER
HOUSING MANAGER

Signed: _____
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241140

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	1	Date	04/29/24
No. of Repeat RF/PHI Categories Out	0	Time In	12:05:06
Legal Authority MN Rules Chapter 4626		Time Out	

Elmhurst Commons	**Address** 400 3rd Street S.W.	**City/State** Braham, MN	**Zip Code** 55040	**Telephone** 6514280646
License/Permit # 0013226	**Permit Holder** Elmhurst Commons, LLC	**Purpose of Inspection** Full	**Est Type**	**Risk Category** H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	IN (OUT) N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	(IN) OUT N/A N/O	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		Safe Food and Water	COS	R
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

		Proper Use of Utensils	COS	R
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) [signature] **Date:** 04/29/24

Inspector (Signature) TM