DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 3, 2025

Licensee
Garden Terrace Assisted Living
426 Mason Drive
Wrenshall, MN 55797

RE: Project Number(s) SL30521016

Dear Licensee:

On January 23, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the November 6, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial 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,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

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Electronically Delivered

December 11, 2024

Licensee
Garden Terrace Assisted Living
426 Mason Dr
Wrenshall, MN 55797

RE: Project Number(s) SL30521016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 6, 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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30521	A. BUILDING: _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN TERRACE ASSISTED LIVING	426 MASON DR WRENSHALL, MN 55797

(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 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: SL30521016-0 On November 5, 2024, through November 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were nine residents reveiving services under the Assisted Living Facility license.	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 November 6, 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		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter	0 780		

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0 780	Continued From page 2 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with State Fire Code in Minnesota Rules, Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 3 The findings include: On November 6, 2024, at 10:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. An inspection tag or sticker was not attached to the fire alarm panel showing an annual inspection had been completed on the fire alarm system. During the facility tour interview on November 6, 2024, LALD-A verified the fire alarm system had not been inspected in the last year. 2. An extension cord was plugged into a multi-plug adapter to supply power in resident sleeping room 2. An extension cord was used to supply power in resident sleeping room 6. In the laundry room, two refrigerators were plugged into a multi-plug adapter. Improper use of extension cords and multi-plug adapters creates a fire hazard. During the facility tour interview on November 5, 2024, LALD-A verified the above listed observation. 3. Carbon monoxide alarms were not installed outside the resident sleeping areas. Carbon monoxide detection shall be installed outside each separate sleeping area within 10 feet. During the facility tour interview on November 6, 2024, LALD-A verified the above listed observation. 4. One illuminated emergency exit sign at the end of the corridor did not have an annual inspection sticker. During the facility tour interview on November 6, 2024, LALD-A stated they did not know if this exit sign was tested and inspected in the last year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 780		

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0 780	Continued From page 4 days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 6, 2024, at 10:00 a.m., the	0 790		

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0 790	Continued From page 5 surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed monthly inspections had not been recorded on the back of the tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview on November 6, 2024, LALD-A verified monthly fire extinguisher inspections had not been completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of residents, staff, and visitors.	0 800		

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0 800	Continued From page 6 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 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: On November 6, 2024, at 10:00 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: 1. In the mechanical room, the backflow prevention device inspection tag was dated 2022. Testable backflow devices must be tested and inspected annually by a certified backflow device tester. 2. One side of the bifold closet door was off the track in resident room 9. 3. The carpet was stained in resident room 9. 4. One downspout for the gutter system was broken on the front of the building. During the facility tour interview on November 5, 2024, LALD-A verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 7 (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: Based on observation, record review, and interview, the licensee failed to develop and maintain a fire safety and evacuation plan with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 8 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 November 6, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP was not developed and maintained evident by the following: On November 6, 2024, at 10:00 a.m., the surveyor toured the facility with LALD-A. During the tour, the surveyor observed the following: - The FSEP emergency procedures for fire were posted in the shadowbox near the front entrance of the facility. The posted FSEP procedures did not match the procedures in the written copy of the FSEP provided by the LALD-A to the surveyor. The FSEP must be accurately maintained in all locations. - The posted FSEP floor plan did not identify an exit route leading to the front main exit of the facility. Exit routes were shown to the back patio and side door of the facility. The route to the main exit for the facility must be identified on the FSEP floor plan. The FSEP shall be developed and maintained to provide efficient communication for exiting in the event of a fire or similar emergency.	0 810		

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0 810	Continued From page 9 The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks evident by a lack of these actions in the plan. The employee actions were limited to the RACE (Rescue, Alarm, Contain, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. The FSEP included procedures and actions that were not accurate to this location evident by the following: - Instructions for residents referenced hallway fire doors that closed automatically. - Exiting locations directed the building occupants to an elevator, a rear exit into an alley by room 113, the second floor, and a front exit to 56th Avenue West. - The fire drill procedure referenced fire doors with magnetic connectors. None of the above listed building elements were observed by the surveyor during the facility tour on November 6, 2024, at 10:00 a.m. with LALD-A. During an interview, on November 6, 2024, at 11:25 a.m., LALD-A verified these procedures were for another assisted living facility. The FSEP failed to include specific fire protection procedures necessary for residents evident by the lack of these procedures in the plan. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents evident by a lack of these procedures in the plan. The plan was limited to directing	0 810		

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0 810	Continued From page 10 employees to evacuate residents and use wheelchairs and blanket drags if residents were non-ambulatory or slow with mobility. The plan for relocation was not clear, it directed employees and residents to meet at the designated location for your program and relocate to a neighbor's house using a van. During an interview on November 6, 2024, at 11:25 a.m., LALD-A stated residents would relocate to the town hall and then to another assisted living facility if needed. The written plan for relocation did not include specific actions or match what was verbally stated by the LALD-A. Nine residents were identified as requiring assistance during an evacuation and procedures for these residents were not included in the plan. During an interview, on November 6, 2024, at 11:25 a.m., LALD-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year. Four resident fire drill training records dated 06/20/2022, 04/11/2023, 07/18/2023, and 10/09/2023 were provided for review. During an interview on November 6, 2024, at 11:25 a.m., LALD-A stated residents were trained during fire drills and no additional training had been completed. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by fire drill reports lacking the required frequency. Evacuation drill records for 2023 and 2024 were requested by the surveyor. The LALD-A provided one fire drill	0 810		

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0 810	Continued From page 11 report dated October 9, 2023. The time or shift of this drill and the names of the employees who participated were not recorded. No additional evacuation fire drill reports were provided. During an interview on November 6, 2024, at 11:25 a.m., LALD-A verified the evacuation fire drill frequency was not met and the required drill documentation had not been recorded on the October 9, 2023, report. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	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 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	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30521	A. BUILDING: _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN TERRACE ASSISTED LIVING	426 MASON DR WRENSHALL, MN 55797

(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
01060	Continued From page 12 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/or 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 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	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30521	A. BUILDING: _____ B. WING _____	11/06/2024

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01060	Continued From page 13 situation has occurred only occasionally). The findings include: R1's diagnoses included a stroke with right sided weakness, diabetes type II and hallucinations. R1's Service Plan dated April 6, 2022, indicated R1 received assistance with dressing, grooming, medication administration, blood glucose and vital signs monitoring, behavior management, safety checks, meals, housekeeping, and laundry. R1's progress notes dated October 22, 2024, through November 1, 2024, indicated R1 was sent to emergency room for self-harm on October 22, 2024, and remained in the hospital awaiting an opening for a mental health placement as of November 1, 2024. R1's record lacked evidence a written notice, including the following required content was provided to R1 or R1's representative or notification was provided to the Office of Ombudsman for Long-Term Care for R1's hospitalization of four days or longer: (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 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	01060		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30521	A. BUILDING: _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01060	Continued From page 14 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. On November 5, 2024, 10:33 a.m., clinical nurse supervisor (CNS)-B stated they were aware of the requirement and it was the licensee's usual practice. CNS-B stated they notified R1's county case manager; however, did not provide a written notice or notify the ombudsman and was unable to provide an explanation of why a written notice was not provided or notification was not sent to the ombudsman. The licensee's Emergency Relocation and Termination policy dated August 1, 2021, in the event of an emergency relocation, the licensee must provide a written notice which includes: - 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 Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return, or a statement that a return date is not currently known; and - if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal and who to contact to proceed with the appeal. The notice must be provided as soon as practicable to the resident, legal representative, designated representative, case manager, and the Ombudsman if the resident has not returned to the facility within four days. No further information was provided.	01060		

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	30521	A. BUILDING: _____ B. WING _____	11/06/2024

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01060	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
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 current services provided for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30521	A. BUILDING: _____ B. WING _____	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01640	Continued From page 16 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 diagnoses included mild intellectual disabilities, type II diabetes, depression, heart failure, chronic kidney disease and cellulitis (bacterial skin infection). On November 6, 2024, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-C provide skin care treatments to R3's lower legs and apply Tubigrip stockings (tubular elastic compression bandage). R3's October and November 2024, service delivery summary indicated R3 received daily blood glucose monitoring, thickened liquids and assistance with putting on and taking off Tubigrips. R3's service plan, dated September 12, 2024, lacked the services of blood glucose monitoring, thickened liquids and assistance with Tubigrip stockings. On November 6, 2024, at 11:22 p.m., clinical nurse supervisor (CNS)-B stated the service plan in R3's paper chart had not been updated to include daily blood glucose monitoring, thickened liquids, or assistance with Tubigrip stockings. CNS-B stated R3's service plan had been updated in the computer; however, CNS-B had not printed the new service plan to have R3	01640		

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	30521	A. BUILDING: _____ B. WING _____	11/06/2024

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GARDEN TERRACE ASSISTED LIVING	426 MASON DR WRENSHALL, MN 55797

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01640	Continued From page 17 review and sign. The licensee's Admission Process for New Residents dated August 1, 2021, indicated each service plan would include a description of services including nursing, medication management services, treatments and or therapy services, to be provided by the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by:	01950		

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01950	Continued From page 18 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of one resident (R3) who received blood glucose monitoring. 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 diagnosis included diabetes mellitus type II. R3's Service Plan dated September 12, 2024, indicated R3 received assistance with activities of daily living (ADL's), medication administration, safety checks, skin cares, housekeeping and laundry. R3's prescriber orders dated September 26, 2024, included daily blood glucose monitoring. R3's October and November 2024, service delivery summary indicated R3 received blood glucose monitoring daily. R3's October and November 2024, medication administration summary indicated daily blood glucose monitoring and provide a snack if R3's blood glucose was below 70 milligrams per deciliter (mg/dl); however, R3's record lacked blood glucose parameters for staff to notify the	01950		

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01950	Continued From page 19 RN or prescriber. On November 5, 2024, at 2:17 p.m., clinical nurse supervisor (CNS)-B stated R3's prescriber did not set blood glucose parameters for R3. CNS-B stated R3's record indicated staff were to offer R3 a snack if R3's blood glucose was below 70 mg/dl; however, did not include blood glucose parameters of when to notify the RN or R3's provider. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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

Type: Full
Date: *11/06/24*
Time: 10:30:00
Report: 1027241140

Food and Beverage Establishment Inspection Report

Location:
Garden Terrace Assisted Living
426 Mason Dr
Wrenshall, MN55797
Carlton County, 09

Establishment Info:
ID #: 0037829
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2183844623
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

PORK IN UPRIGHT COOLER WAS THAWING OVER READY TO EAT FOODS SUCH AS SALAD. STAFF MOVED PORK TO A LOWER SHELF. COS

Corrected on Site

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

STAFF WERE STORING DISH OF BUTTER ON COUNTERTOP. STAFF DISCARDED BUTTER. COS

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Food and Beverage Establishment Inspection Report

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: TURKEY HOTDISH
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: THERMOMETER
Violation Issued: No

Process/Item: Chest Freezer
Temperature: Degrees Fahrenheit - Location: ALL FOODS FROZEN
Violation Issued: No

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

DISCUSSED EMPLOYEE ILLNESS AND EXCLUSIONS, REQUIRED SANITIZER STRENGTHS, AND AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS.

Type: Full
Date: *11/06/24*
Time: 10:30:00
Report: 1027241140
Garden Terrace Assisted Living

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 1027241140 of 11/06/24.

Certified Food Protection Manager: NANCY HILLSTROM

Certification Number: FM94247 Expires: 06/01/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
NANCY HILLSTROM
MANAGER

Signed: Ian Harrison
Ian H

651-201-4500
health.foodlodging@state.mn.us

Report #: 1027241140

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

MN Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	2
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 11/06/24
Time In 10:30:00
Time Out

Garden Terrace Assisted Living	Address: 426 Mason Dr	City/State: Wrenshall, MN	Zip Code: 55797	Telephone: 2183844623
License/Permit #: 0037829	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

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
Surpervision							
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	X	
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	X	
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

			COS	R
Safe Food and Water				
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		

			COS	R
Proper Use of Utensils				
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) **Date:** 11/07/24

Inspector (Signature) Dan Harrison