Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 20, 2023

Licensee
Suncrest Assisted Living
2400 Washington Avenue
Scanlon, MN 55720

RE: Project Number(s) SL33414015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 23, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33414	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNCREST ASSISTED LIVING	2400 WASHINGTON AVENUE SCANLON, MN 55720

(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: SL33414015-0 On August 21, 2023, through August 23, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 42 active residents; 26 receiving services under the Assisted Living 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 included document titled, Food and Beverage Establishment Inspection Report dated August 22, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in	0 485		

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0 485	Continued From page 2 advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect 42 all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 21, 2023, at 11:05 a.m., during a tour of the facility with licensed assisted living director in residence (LALDIR)-A and clinical nurse supervisor (CNS)-C, the surveyor observed a menu posted on the kitchen refrigerator dated: - August 6th, 2023, through August 12, 2023 - August 13, 2023, through August 19, 2023. The surveyor did not observe an up to date menu for the day or for the week posted in the assisted living.	0 485		

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0 485	Continued From page 3 Directly after the observation above, LALDIR-A said the caterer did not get the menu to the facility for the week "yet". LALDIR-A checked her phone and stated, here it (menu) is now, I'll get it posted. LALDIR-A added the cook (caterer) was working short staffed. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=E	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure infection control standards were followed by two of four unlicensed personnel ((ULP)-G, ULP-E) during medication administration for R4, R10, R5. In addition, one of two ULP (ULP-H) failed to ensure reusable equipment was cleaned in-between resident use (R2, R6).	0 510		

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0 510	Continued From page 4 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: HAND HYGIENE ULP-G On August 21, 2023, at 12:59 p.m., the surveyor observed ULP-G remove two (2) 500 milligram (mg) acetaminophen from R4's locked medication cabinet. ULP-G had one black glove on and applied another black glove. ULP-G administered the medication and documented the medication as administered. ULP-G removed the gloves. The surveyor did not observe ULP-G wash her hands or apply hand sanitizer before applying gloves or after removal of gloves. On August 21, 2023, at 1:23 p.m., the surveyor observed ULP-G go in the direction of R10's room. ULP-G commented on the way to R10's room that she had to "grab" some more gloves from the kitchen. The surveyor observed ULP-G remove two (2) 500 mg acetaminophen tablets from a locked medication cabinet in R10's room. ULP-G placed the medication into a medication cup and set the medication cup near R10. The surveyor did not observe ULP-G perform hand hygiene before or after R10's medication administration. Directly following the above observation ULP-G	0 510		

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0 510	Continued From page 5 stated, "yes, yes, yes, I should change gloves. I'll be honest with you. I didn't wash in-between medication pass." On August 21, 2023, at 3:04 p.m., clinical nurse supervisor (CNS)-C stated ULPs should wash hands after removing gloves. CNS-C added the expectation was hand washing should be done before "we" put the gloves on and if not visible soiled sanitizer may be used. ULP-E On August 22, 2023, at 8:48 a.m., the surveyor observed ULP-E apply gloves and document two (2) 500 mg tablets of acetaminophen had been given to R5. ULP-E then unlocked R5's medication cabinet and removed R5's morning medication and administered them to R5. The surveyor did not observe ULP-E perform hand hygiene prior to glove application. On August 22, 2023, at 11:27 a.m., ULP-E stated she washed hands or used sanitizer after assisting each client, ULP-E stated she does not wash her hands with glove changes. On August 22, 2023, at 11:48 a.m., registered nurse (RN)-D stated hands should be washed in between residents, adding sanitizer could be used three (3) times, then hands were to be washed. REUSABLE EQUIPMENT On August 22, 2023, at 8:04 a.m., the surveyor observed ULP-H place a pulse oximeter (SpO2 monitor- probe that may be attached to a patient's finger, toe, nostril, or earlobe. The monitor then displays a reading of how saturated the patient's blood is with oxygen) on R2's finger. ULP-H then placed the SpO2 monitor into her pocket. The	0 510		

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0 510	Continued From page 6 surveyor did not observe ULP-H clean the SpO2 monitor prior to use or after use. On August 22, 2023, at 8:21 a.m. the surveyor observed ULP- H apply a wrist blood pressure (BP) cuff onto R6's right wrist. ULP-H returned the BP cuff to a basket she had got the BP cuff from. The surveyor did not observe ULP-H clean the BP cuff prior to use or after use. On August 22, 2023, at 8:45 a.m., ULP-H stated she "usually cleans them (reusable equipment), adding "I forgot to bring wipes with me." On August 22, 2023, at 11:47 a.m., RN-D stated reusable equipment was to be cleaned between every resident. The licensee's Hand Hygiene policy dated May 8, 2017, noted hand-washing was the single most effective way of preventing and controlling the spread of infection, and would be performed by staff routinely and thoroughly to protect residents from the spread of infection. Hands should be washed: -before and after direct contact with a resident -before and after contact with environmental surfaces or equipment in the immediate vicinity of the resident -after removing gloves or gowns. Use of hand sanitizers- in other situations, alcohol-based hand sanitizers that are at least 60% alcohol may be used to decontaminate hands, instead of soap and water: -when soap and water are not available -when hands do not appear to be soiled -before and after assisting a resident when not in contact with bodily fluids -before and after contact with environmental surfaces or equipment in the immediate vicinity of	0 510		

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0 510	Continued From page 7 the resident -between glove changes. -before leaving the room and if not in direct physical contact with a resident or resident's environmental surfaces or equipment since last washing hands. The licensee's Cleaning/Disinfecting Resident Care Equipment policy dated January 25, 2022, noted: - reusable items are cleaned and disinfected between residents (e.g. stethoscopes) -reusable resident care equipment would be decontaminated between residents according to manufacturer's instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 8 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on August 21, 2023, at 11:08 a.m., the surveyor observed the entry area, common areas, and dining area within the facility with licensed assisted living director in residence (LALDIR)-A and did not observe signage posted or information regarding the licensee's EPP. Directly after the above observation LALDIR-A stated the EPP was in the nurse's office and was	0 680		

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0 680	Continued From page 9 in their on-line system for staff. LALDIR-A said the EPP was not located in the common's area nor was signage posted regarding the EPP's location. On August 21, 2023, at 3:13 p.m., LALDIR-A stated registered nurse (RN)-D would be at the site around 8:00 a.m., on August 22, 2023, to discuss the facilities EPP. LALDIR-A said the "red" binder given to the surveyor was old. LALDIR-A stated RN-D emailed her a couple of things, "2 or 3 pages" last week, adding she had not done anything with them (pages) yet. The licensee's EPP, provided to the surveyor was in a binder named "Emergency Policies." There was not a date on the binder, and the EPP binder did not include the following: - a completed hazard vulnerability assessment (HVA) - a quarterly review of the missing resident policy - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a description of the population served by the licensee; - development of policies/procedures to address: - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - updated shelter in place (last reviewed/amended October 23, 2017); - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if	0 680		

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0 680	Continued From page 10 needed (last reviewed/amended January 8, 2018); - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers (last reviewed/ amended October 23, 2017); - arrangement with other facilities; - contact information for federal, state, tribal, ombudsman; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families (last reviewed/amended January 18, 2018). On August 22, 2023, at 9:31 a.m., RN-D stated the facility did not have an up to date EPP. The red binder named "Emergency Policies" did not contain a risk assessment; however RN-D added their on-line system indicated a risk assessment had been completed on August 1, 2023. The surveyor reviewed the red binder with RN-D. RN-D confirmed many of the policies were outdated and the policies dated 2021, had not been reviewed annually. RN-D added the call list was old, and the plan had not been posted as required. The licensee's Hazard Vulnerability Assessment (HVA) policy dated April 1, 2019, noted the HVA process would be completed annually or if an incident occurred. The licensee's Emergency Call List policy dated August 1, 2021, noted the Emergency Call List	0 680		

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0 680	Continued From page 11 would be updated annually or if there was a significant change. The licensee's Emergency Communication Plan dated August 1, 2021, noted the emergency communication plan must include all of the following: -names and contact information for: staff, entities providing services under arrangement, resident physicians, volunteers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 710 SS=D	144G.43 Subdivision 1 Resident record (c) The facility may not disclose to any other person any personal, financial, or medical information about the resident, except: (1) as may be required by law; (2) to employees or contractors of the facility, another facility, other health care practitioner or provider, or inpatient facility needing information in order to provide services to the resident, but only the information that is necessary for the provision of services; (3) to persons authorized in writing by the resident, including third-party payers; and (4) to representatives of the commissioner authorized to survey or investigate facilities under this chapter or federal laws. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure resident's personal health and medical information was kept private for one of	0 710		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNCREST ASSISTED LIVING	2400 WASHINGTON AVENUE SCANLON, MN 55720

(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
0 710	Continued From page 12 four residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 22, 2023, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-H administer R2's morning medication. ULP-H mentioned to R2 that she was going to R6's room next. ULP-H added, R6 took "a lot of medication". R2 replied to ULP-H's comment, asking ULP-H how was R6 doing? ULP-H replied R6 was doing ok. On August 22, 2023, at 11:49 a.m., registered nurse (RN)-D stated it was not "ok" for ULPs to disclose health related information between residents. The licensee's Confidentiality & Protection of Resident Records policy dated August 1, 2021, noted resident records were: -protected against loss, tampering or unauthorized disclosure in compliance with State and Federal regulation -all care center staff were informed upon hire of the confidentiality policy -any breach of confidentiality may be cause for immediate disciplinary action up to and including termination -contents of the resident's medical record are	0 710		

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0 710	Continued From page 13 considered confidential information No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 710		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 800		

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0 800	Continued From page 14 On a facility tour on August 22, 2023, at approximately 11:00 a.m. with maintenance supervisor (MS)-B it was observed that the fire-resistant rated door leading into the south wing near the administration offices does not self-close and latch. Fire resistant rated doors are required to automatically close and latch. It was also observed that glycol from the central hot water heating system pump (the left of the two pumps) in the boiler room was leaking from the pump seal onto the floor. The heating system is required to be maintained free of glycol leaks that cause damage to the floor levels below the leak. It was also observed that a blue poly tarp was used to repair a leak on the roof. Roof covering material is required to be maintained free of leaks as approved at the time of construction. It was observed that metal trim had come off on the roofs edge on the front side of the building. The metal trim is required to be maintained to prevent water intrusion of the structure. These deficient conditions were visually verified by MS-B accompanying on the tour. 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: (1) location and number of resident sleeping	0 810		

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0 810	Continued From page 15 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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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	0 810		

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0 810	Continued From page 16 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). Findings include: A record review of available documentation and interview were conducted on August 22, 2023, at approximately 10:15 a.m. of documents provided by maintenance supervisor (MS)-B, licensed assisted living director in residence (LALDIR)-A and registered nurse (RN)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan. The plan that was provided had not been updated to be specific to this facility. Record review of the available documentation indicated that the licensee did not provide number and location of resident rooms on the fire safety and evacuation floor plan. Resident room numbers are required to be included on the fire safety and evacuation floor plan for more accurate reference and communication of direction for evacuation. Record review of the available documentation indicated that the licensee included employee actions related to fire safety and evacuation but did not have specific employee actions for this facility located within the plan. Record review of the available documentation	0 810		

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0 810	Continued From page 17 indicated the licensee did not have detailed unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency available with the fire safety and evacuation plan. Individual unique and unusual needs of each resident for evacuation during a fire or similar emergency is required to be available with the fire safety and evacuation plan in order to help communicate evacuation needs to staff and emergency personnel. Record review of the available documentation indicated the fire safety and evacuation plan was not available at all times within the facility. At the time of survey, the updated fire safety and evacuation plan had been misplaced and was not available. The fire safety and evacuation plan is required to be available within the building at all times. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Resident training on the fire safety and evacuation plan for the facility is required to be offered to the residents once annually. Record review of the available documentation indicated that evacuation drills had been conducted in October of 2022 and no other documentation of fire or similar emergency evacuation drills was available. Evacuation drills for staff are required to be conducted every other month and twice per year per shift and documented separately from employee training. All deficiencies were verified by MS-B, LALDIR-A	0 810		

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0 810	Continued From page 18 and RN-D during the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for	01440		

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01440	Continued From page 19 the licensee for three of three unlicensed personnel ((ULP)-E, ULP-I, ULP-K). 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-E ULP-E was hired on December 20, 2021, to provide direct care services to the facility's residents. On August 22, 2023, at 8:48 a.m., the surveyor observed ULP-E enter R8's room and document two (2) 500 milligrams (mg) tablets of acetaminophen (mild pain) had been given. ULP-E's employee record did not include documentation of a registered nurse (RN) supervising ULP-E performing a delegated task within 30 days of beginning work with the licensee. ULP-I ULP-I was hired on July 11, 2019, to provide direct care services to the facility's residents, and began providing assisted living services on August 1, 2021. ULP-I's employee record did not include documentation of a RN supervising ULP-I performing a delegated task within 30 days of	01440		

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01440	Continued From page 20 beginning work with the licensee. ULP-K ULP-K was hired on October 11, 2022, to provide direct care services to the facility's residents. ULP-K's employee record did not include documentation of a RN supervising ULP-K performing a delegated task within 30 days of beginning work with the licensee. On August 23, 2023, at 11:11 a.m., registered nurse (RN)-D stated supervision of staff performing delegated tasks had not been completed as required. The licensee's Supervision of Licensed & Unlicensed Personnel policy dated August 1, 2021, noted, direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person began working for the agency and had been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500		

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01500	Continued From page 21 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500		

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01500	Continued From page 22 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all of the required annual training content for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-F, ULP-I). 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 ULP-F was hired on September 22, 2009, and began providing assisted living services on August 1, 2021. On August 21, 2023, at 12:41 p.m., the surveyor observed ULP-F assisting residents in the kitchen area.	01500		

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01500	Continued From page 23 ULP-F's employee record did not include the following required annual training: -review of the facility's policies and procedures related to the provision of assisted living services and how to implement those policies and procedures. ULP- I ULP-I was hired on July 11, 2019, and began providing assisted living services on August 1, 2021. On August 22, 2023, at 6:49 a.m., the surveyor observed ULP-I assisting with resident's laundry and later assisting in the kitchen with resident's breakfast. ULP-I's employee record did not include the following required annual training: -review of the facility's policies and procedures related to the provision of assisted living services and how to implement those policies and procedures. On August 22, 2023, at approximately 3:30 p.m., registered nurse (RN)-D stated she thought a review of the facility's policies and procedures was completed during annual training for ULPs but added "that RN" was no longer working at the facility. On August 22, 2023, at approximately 4:15 a.m., RN-D stated ULP-F and ULP-I's annual training did not include a review of the facility's policies and procedures as required. The licensee's Orientation and Annual Training policy dated August 1, 2021, noted all staff that perform direct-care services would complete at	01500		

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01500	Continued From page 24 least eight (8) hours of annual training for each 12 months of employment. The training may be obtained from the care center or another source and would include topics relevant to the provision of assisted living services. The annual training would include: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for two of four residents (R4,	01750		

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01750	Continued From page 25 R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R4 R4's diagnoses included cornea transplant (removal of either the entire thickness or partial thickness of the diseased cornea and replaced it with health donor tissue). R4's service plan dated July 31, 2023, indicated R4 received services which included medication administration. R4's prescriber's order dated June 9, 2023, included: -prednisolone acetate (eye inflammation) 1% (white or pink top) four (4) times a day (you will take this eye drop for at least one (1) year to prevent rejection of the new cornea) -shake the bottle prior to using -close your eye for ten (10) seconds after placing the eye drop -wait for at least one (1) minute in between eye drops, so that they do not wash out. R4's medication administration record (MAR) dated August 1, 2023, through August 22, 2023, included:	01750		

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01750	Continued From page 26 -prednisolone acetate ophthalmic suspension 1%, four (4) times per day, every day at 8:00 a.m., 12:00 pm, 4:00 p.m., 8:00 p.m. Additional notes: give 1 drop to right eye 4 times daily (bottle is white or pink cap). Close eye for ten (10) seconds after placing the eye drop (will be on for at least one (1) year.) R4's August 2023 MAR did not include directions to shake the bottle prior to using. On August 22, 2023, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-H administer one (1) drop of prednisolone acetate into R4's right eye. The surveyor did not observe ULP-H shake the bottle of prednisolone eye solution prior to administration. On August 22, 2023, at 2:11 p.m., RN-D stated R4's MAR should have included directions for staff to shake the bottle of the eye solution prior to administration. The manufacturer's instructions for prednisolone acetate dated November 12, 2020, noted: - it was important to shake the bottle well before use. R8 R8's diagnoses included hypothyroidism (when thyroid gland doesn't make enough thyroid hormone). R8's service plan dated July 5, 2023, indicated R8 received services which included medication administration. R8's MAR dated August 1, 2023, through August 22, 2023, included: -levothyroxine sodium oral tablet 100 micrograms	01750		

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01750	Continued From page 27 (mcg), one (1) tablet by mouth one (1) time per day every day at 8:00 a.m., On August 22, 2023, at 8:48 a.m., the surveyor observed ULP-E enter R8's room and document two (2) 500 milligrams (mg) tablets of acetaminophen (mild pain) had been given. On August 22, 2023, at 1:05 p.m., RN-D reviewed R8's MAR with surveyor. RN-D said the entry on R8's MAR for levothyroxine should have included instructions for ULPs to follow "to sit up for 30 minutes after taking the medication..." The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted: a registered nurse may delegate medication administration to unlicensed personnel only after the RN had: -developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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 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	01760		

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01760	Continued From page 28 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 as ordered for two of five residents (R8, R4) who received medication management 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 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: MEDICATION ADMINISTRATION/TIMING AND DOCUMENTATION R8's diagnoses included depression, chronic pain, and weakness. R8's service plan dated July 5, 2023, 2023, indicated R8 received services which included medication administration. On August 22, 2023, at 8:48 a.m., the surveyor observed unlicensed personnel (ULP)-E enter R8's room and document two (2) 500 milligrams	01760		

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01760	Continued From page 29 (mg) tablets of acetaminophen (mild pain) had been given. The surveyor did not observe ULP-E administer acetaminophen to R8. Directly after the above observation ULP-E stated R8 had requested acetaminophen earlier and the system would not allow ULP-E to document medication administration at that time. ULP-E said she was documenting the administration of the medication "now", as the system allowed. ULP-E added acetaminophen should be an as needed (PRN) medication and she was "going" to ask about getting the order changed. R8's August 1, 2023, through August 22, 2023, medication administration record (MAR) included: -acetaminophens extended release 500 mg oral capsules, two (2) capsules by mouth three (3) times per day, every day at 9:30 a.m., 3:00 p.m., 8:00 p.m. On August 22, 2023, at 12:58 p.m., clinical nurse supervisor (CNS)-C stated ULPs have one hour before or after the scheduled time on the MAR to give a medication, adding ULP-E should have called nurse. In addition, CNS-C said ULPs should not give medication early and later document medication administration. MEDICATION ADMINISTRATION/DIRECTION R4's diagnoses included cornea transplant (removal of either the entire thickness or partial thickness of the diseased cornea and replaced it with health donor tissue). R4's service plan dated July 31, 2023, indicated R4 received services which included medication administration. On August 22, 2023, at 7:35 a.m., the surveyor	01760		

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01760	Continued From page 30 observed ULP-H assist R4 use the remote control to recline R4 in the chair R4 was positioned in. ULP-H administered one (1) drop of prednisolone acetate (eye inflammation) into R4's right eye. The surveyor did not observe ULP-H instruct R4 to close her eye for ten (10) seconds. On August 22, 2023, at 7:39 a.m., ULP-H stated R4 "usually will lay head back, she is so hard of hearing". ULP-H said she did not give R4 direction to close her eyes. R4's medication administration record dated August 1, 2023, through August 22, 2023, included: -prednisolone acetate ophthalmic suspension 1%, four (4) times per day: every day at 8:00 a.m., 12:00 pm, 4:00 p.m., 8:00 p.m. Additional notes: give one (1) drop to right eye for (4) times daily (bottle is white or pink cap). Close eye for ten (10) seconds after placing the eye drop (will be on for at least one (1) year.) R4's prescriber's order dated June 9, 2023, included: -prednisolone acetate 1% (white or pink top) four (4) times a day (you will take this eye drop for at least one (1) year to prevent rejection of the new cornea) -shake the bottle prior to using -close your eye for ten (10) seconds after placing the eye drop -wait for at least one (1) minute in between eye drops, so that they do not wash out. On August 22, 2023, at 2:11 p.m., registered nurse (RN)-D stated R4 should have been "told" to close her eye after eye drop administration. The licensee's undated Documentation of	01760		

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01760	Continued From page 31 Medication, Treatment, and Therapy Management Services policy noted: -staff would document each task immediately after that task had been performed. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted: a registered nurse may delegate medication administration to unlicensed personnel only after the RN had: -instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel had demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD OF 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	01790		

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01790	Continued From page 32 nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before 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,	01790		

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01790	Continued From page 33 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 one of one unlicensed personnel (ULP-G) 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 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-G was hired on May 16, 2023, to provide direct care services to the facility's residents. On August 21, 2023, at 1:17 p.m., the surveyor observed ULP-G enter R5's room, check R5's medication administration record and apply lidocaine spray (pain) to R5's lower back. ULP-G's record lacked evidence to indicate ULP-G had been trained and had demonstrated competency to prepare and provide medications to residents for unplanned times away from home. On August 22, 2023, at 4:13 p.m., registered nurse (RN)-D stated she wished she had better	01790		

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01790	Continued From page 34 news, adding training had not been completed for any of the ULPs working at the facility for preparing and providing medications to residents for unplanned time away. The licensee's undated Medications When Resident is Away from Home policy noted only resident assistants (ULP) that have been trained and have satisfactorily demonstrated competency would be assigned to place medications prepared by a pharmacist or a licensed nurse in the appropriate container for an unplanned leave of absence not to exceed seven (7) days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=E	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 medication was secured in a locked area for two of five residents (R5, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01880		

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01880	Continued From page 35 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: R5 R5's diagnoses included diabetes, hypertension (HTN-high blood pressure), and shingles (painful, usually itchy, rash that develops on one (1) side of the face or body, following nerve line) R5's service plan dated March 23, 2023, included: -RA (resident assistance/unlicensed personnel/ULP) to watch resident take all medications before leaving resident's room -medications would be stored in a locked cabinet in the resident's apartment, only staff trained to administer medication had a key. R5's assessment dated June 29, 2023, included: Medication Management -resident needs assistance with medication storage: yes, medications stored in locked cabinet above stove. R5's prescriber's orders dated August 22, 2023, included lidocaine pain relief max external aerosol 4%, one (1) spray as needed one (1) time per day, to shingles affected area of pain (chest, back, under breast. OK TO SELF ADMINISTER). On August 21, 2023, at 1:17 p.m., the surveyor observed ULP-G enter R5's room, check R5's medication administration record (MAR) and apply lidocaine spray to R5's lower back. The lidocaine spray was located on the kitchen table	01880		

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01880	Continued From page 36 in R5's room. The lidocaine spray was not stored in the locked cabinet. R6 R6's diagnoses included HTN, anxiety, depression and panic attacks. R6's service plan dated July 18, 2023, included: -medication storage, all medication would be stored in a locked cabinet in residents' apartment. Only staff had a key. R6's assessment dated July 18, 2023, included: Medication Management -resident needs assistance with medication storage, yes, medications stored in locked cabinet above stove. On August 22, 2023, at 8:21 a.m., the surveyor observed ULP-H prepare and administer R6's morning medication. ULP-H was not able to locate Occuvite/lutein (eye) vitamin in the locked medication cabinet. The surveyor observed an opened container of AREDS 2 Preservision (eye) vitamins behind a pitcher of water on R6's kitchen counter. The bottle of eye vitamins was not stored in the locked cabinet. Directly after the above observation ULP-H stated she did not know R6 had her "own" vitamins, adding it is "hard" when resident's go out themselves. On August 22, 2023, at approximately 12:30 p.m., clinical nurse supervisor (CNS)-C stated even though the prescriber's order stated R5 could self-apply the lidocaine spray it should have been secured. CNS-C stated she just changed R5's medication plan, to allow R5 to keep lidocaine spray in an unsecured location. CNS-C said she	01880		

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01880	Continued From page 37 was not aware R6 had unsecured medications in her room, adding R5's and R6's medications should have been stored in a secured location. The licensee's Storage of Medications policy dated January 6, 2021, noted a registered nurse must conduct a face-to-face nursing assessment of a resident's need for medication management services, including the appropriate method to store the resident's medications and whether secured storage was appropriate given the resident's functional and cognitive status, concern about the potential for drug diversion or other considerations. Based on this assessment the RN would develop an individualized medication management plan for the resident that would address storage of the resident's medications. When secured storage of the medications was necessary, the RN would identify where the medications would be stored, how they would be secured or locked under proper temperature controls and who had access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	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	01890		

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01890	Continued From page 38 by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of two residents (R4) and failed to monitor for expired medications for one of six residents (R7). 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: TIME SENSITIVE MEDICATION On August 21, 2023, at 12:59 p.m., the surveyor observed unlicensed personnel (ULP)-G administer Pred-Forte (inflammation or injury) eye solution into R4's eyes. The bottle of Pred-Forte eye solution did not have a date written on the bottle of when solution had been opened or when solution would expire. Directly following the above observation ULP-G stated, "no one told me to date eye drops when opened, should I be"? On August 22, 2023, at 10:34 a.m., clinical nurse supervisor (CNS)-C stated eye drops should be dated when opened. The manufacturer's instructions for Pred-Forte	01890		

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01890	Continued From page 39 eye solution dated February 2022, indicated discard the bottle 28 days after opening, even if there was solution remaining. EXPIRED MEDICATION R7 -15 lorazepam (anxiety) 0.5 milligram (mg) tablets expired June 21, 2023 -17 Dilaudid (severe pain) 2 mg tablets expired June 21, 2023. On August 22, 2023, at approximately 7:00 a.m., CNS-C stated R7 was a Hospice patient. CNS-C said she doesn't look at Hospice medications as much as "I" should. CNS-C removed R7's expired medication. The licensee's Storage of Medications policy dated January 6, 2021, noted drugs must be kept in original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication. In addition, manufacturer's recommendations would be followed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=E	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 40 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for two of three residents (R1, R9) upon discharge. 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:	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33414	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNCREST ASSISTED LIVING	2400 WASHINGTON AVENUE SCANLON, MN 55720

(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
01910	Continued From page 41 R1 R1 was admitted on January 23, 2023, and discharged on July 14, 2023. R1's diagnoses included Parkinson's disease (brain disorder that causes unintended or uncontrollable movements), gout (accumulation of urate crystals in joints), restless leg syndrome (condition that causes an uncontrollable urge to move legs) and hypertension (HTN-high blood pressure.) R1's service plan dated May 2, 2023, included: -nurse reviewed medications for accuracy and set up prior to RA (resident assistant/unlicensed personnel (ULP) -staff provided reminders/assistance more than 5 times daily -medication would be locked in apartment. Only trained staff had access to medications. R1's medication administration record (MAR) dated June 1, 2023, through June 26, 2023, included: -lisinopril (heart) 10 milligrams (mg) daily -MiraLAX (constipation) 17 grams (gr) daily -pramipexole dihydrochloride ER (extended release) 0.75 mg (restless legs) daily -sinemet CR (Parkinson's) 50-200 mg five (5) times daily -allopurinol (gout) 300 mg daily -Carbidopa-Levodopa (Parkinson's) 25-100 mg seven (7) times daily -docusate sodium (stool softener) 100 mg daily R1's prescriber's orders dated June 21, 2023, included all of the above orders. R1's Discharge Summary dated July 7, 2023, noted, medications disposition: "medications	01910		

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	33414	A. BUILDING: _____ B. WING _____	08/23/2023

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01910	Continued From page 42 were managed by home care and were given to; at the time of discharge. See Medication list for specifics. R1's record lacked a disposition of medications to include: - the mediation name - strength - prescription number as applicable - quantity - to whom the medications were given - date of disposition - names of staff and other individuals involved in the disposition. On August 22, 2023, at 3:52 p.m., registered nurse (RN)-D stated she was "guessing" R1's medication "rec" (disposition of medications) was not completed, a list of discharged medications was not found in R1's record as required. R9 R9 was admitted on April 27, 2023, and discharged on August 4, 2023. R9's diagnoses included HTN, diabetes, and congestive heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs) and bipolar disorder (mental illness causing unusual shifts in mood, energy, activity levels, and concentration.) R9's service plan dated May 16, 2023, included: -nurse reviewed medications for accuracy and set up prior to RA -staff provided reminders/assistance with 4-5 times a day -medication would be locked in apartment. Only trained staff had access to medications.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33414	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNCREST ASSISTED LIVING	2400 WASHINGTON AVENUE SCANLON, MN 55720

(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
01910	Continued From page 43 R9's prescriber's orders dated May 9, 2023, included: -aspirin 81 mg daily -Breo Ellipta inhalator (asthma) 200-25 micrograms (mcg), one (1) inhalation daily -Celexa (depression) 20 mg daily -cranberry extract (supplement) 250 mg, twice daily -Crestor 20 mg (high cholesterol) daily -Depakote 250 mg (bipolar) twice daily -ferrous sulfate (health supplement) 325 mg daily -gabapentin (nerve pain) 100 mg twice daily -isosorbide mononitrate (HTN) daily -levothyroxine (hypothyroidism) 50 mcg -loratadine (allergies) daily -magnesium oxide (health supplement) 240 mg daily -melatonin (sleep) 10 mg daily -metoprolol-HCTZ (hydrochlorothiazide) (heart) 25-12.5 mg daily -MiraLAX (constipation) twice daily -pantoprazole sodium (gastro-esophageal reflux (GERD) daily -Plavix (heart) 75 mg daily -ropinirole HCl (restless legs) 2 mg twice daily -senna (constipation) 8.5 mg daily -torsemide (heart) 20 mg twice daily -Tresiba subcutaneous (diabetes)s 100 units daily -Victoza (diabetes) 18/ 3 milliliters (ml), 1.2 mg, daily. R9's record lacked a disposition of medications to include: - the mediation name - strength - prescription number as applicable - quantity - to whom the medications were given - date of disposition - names of staff and other individuals involved in	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33414	A. BUILDING: _____ B. WING _____	08/23/2023

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SUNCREST ASSISTED LIVING	2400 WASHINGTON AVENUE SCANLON, MN 55720

(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
01910	Continued From page 44 the disposition. On August 23, 2023, at approximately 9:45 a.m., RN-D stated R1 and R9's records did not contain a disposition of medication as required. The licensee's undated Disposition or Disposal of Medications policy, noted documentation of the destruction, listing the date, quantity name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be record and maintained in the resident's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=F	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	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SUNCREST ASSISTED LIVING	2400 WASHINGTON AVENUE SCANLON, MN 55720

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01950	Continued From page 45 each resident and documented those instructions in the resident's record; and 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) prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R2) with blood glucose (sugar) monitoring, and for one of one resident (R2) with orthostatic blood pressure (BP) (obtain BP and record while in supine (laying) position as well as in the standing or sitting position) 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2's diagnoses included diabetes and history of falls. R2's service plan dated July 10, 2023, included: -diabetes management: complete BS (blood sugar), goal range-call nurse if < or> # nurse monitors and updates prescriber as necessary. On August 22, 2023, at 8:04 a.m., the surveyor observed unlicensed personnel (ULP)-H use correct technique to obtain R2's blood sugar reading of 143.	01950		

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01950	Continued From page 46 BLOOD GLUCOSE MONITORING R2's August 1, 2023, through August 21, 2023, medication administration record (MAR) included: -True Metrix Meter Device: test blood glucose one (1) time a day in a.m., before breakfast, one (1) strip externally one (1) time per day every day at 7:00 a.m.-10:00 a.m. R2's prescriber's order dated June 27, 2023, included: -True Metrix Meter Device: one (1) strip externally, one (1) time per day, every day at 7:00 a.m.-10:00 a.m. Test blood glucose one (1) time a day in a.m., before breakfast. On August 21, 2023, at 2:35 p.m., clinical nurse supervisor (CNS)-C stated blood sugar parameters are always 100-200 "around there", adding "I just know if it gets over 350 you would call a doctor, and if low to give orange juice. CNS-C said R2's MAR did not include specific instructions for ULPs to follow regarding R2's blood sugar readings. ORTHOSTATIC BLOOD PRESSURE R2's August 1, 2023, through August 21, 2023, MAR included: -orthostatic blood pressure for seven (7) days, one (1) time per day, every week on Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday at 8:00 a.m., special instructions: report to provider for low blood pressures. R2's prescriber's order dated July 26, 2023, included: -nursing, please obtain orthostatic blood pressures and daily BPs x 7 days; report results to provider via portal for low blood pressures.	01950		

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	33414	A. BUILDING: _____ B. WING _____	08/23/2023

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SUNCREST ASSISTED LIVING	2400 WASHINGTON AVENUE SCANLON, MN 55720

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01950	Continued From page 47 On August 22, 2023, at 2:40 pm., CNS-C stated R2's MAR did not include instructions of when to report R2's ortho blood pressures. CNS-C added R2's blood pressure order should have been discontinued. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, noted: -treatments or therapy tasks may be delegated or assisted by a licensed health professional to unlicensed personnel according to the licensed heath professional's applicable licensing practice standards. When a treatment or therapy was delegated or assigned to unlicensed personnel, the RN or authorized licensed health professional must: -develop written specific instructions for each resident and document those instructions in the resident's record. -developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 48 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure signage was posted at the main entry of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all 42 residents, staff and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On August 21, 2023, at 9:45 a.m., the surveyor entered the facility and observed no signage posted at the entrance or areas immediately adjacent to the entry regarding electronic monitoring. On August 21, 2023, at 11:11 a.m., licensed assisted living director in residence (LALDIR)-A and the surveyor toured the facility. LALDIR-A stated there was no signage posted regarding electronic monitoring, adding they did not have cameras. On August 23, 2023, at 11:08 a.m., registered nurse (RN)-D stated there was no signage posted for electronic monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 49 (21) day	03090		

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

Type: Full
Date: *08/22/23*
Time: 11:00:00
Report: 1027231107

Food and Beverage Establishment Inspection Report

Location:
Suncrest Assisted Living
2400 Washington Avenue
Scanlon, MN55720
Carlton County, 09

Establishment Info:
ID #: 0038792
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188781180
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

PROVIDE THERMOLABELS OR A NON-REVERSIBLE TEMPERATURE MEASURING DEVICE FOR MEASURING DISH MACHINE TEMPERATURES.

Comply By: 09/22/23

Food and Equipment Temperatures

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

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: CREAM CHEESE
Violation Issued: No

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

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

Type: Full
Date: *08/22/23*
Time: 11:00:00
Report: 1027231107
Suncrest Assisted Living

Food and Beverage Establishment Inspection Report

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

INSPECTION CONDUCTED BY SANITARIAN CLIFF LAVIGNE.

TWO MEALS PER DAY ARE SERVED (LUNCH AND DINNER).

TEMP LOGS ARE KEPT FOR CATERED ITEMS.

THE ESTABLISHMENT RE-HEATS PRE-COOKED BURRITOS AND/OR TOAST FOR BREAKFAST.

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 1027231107 of 08/22/23.

Certified Food Protection Manager: N/A

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

JAMES LAMOREAUX
MANAGER

Signed: Ian Harrison

Ian H

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

Report #: 1027231107

Food Establishment Inspection Report

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

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

Date 08/22/23
Time In 11:00:00
Time Out

Suncrest Assisted Living	Address: 2400 Washington Avenue	City/State: Scanlon, MN	Zip Code: 55720	Telephone: 2188781180
License/Permit #: 0038792	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		
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

						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	X	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:** 09/08/23

Inspector (Signature) Dan Harrison