August 18, 2023

Licensee
Eagle Crest Arbor
2955 Lincoln Drive
Roseville, MN 55113

RE: Project Number(s) SL24032015

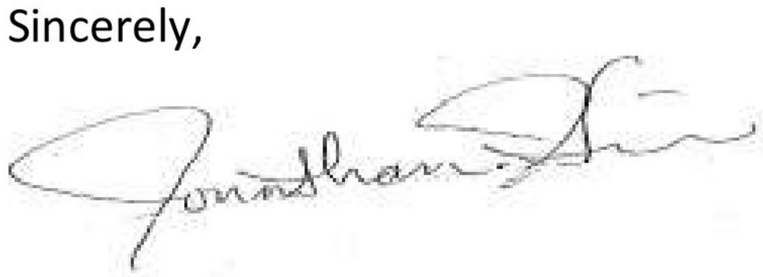
Dear Licensee:

On August 2, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 25, 2023, 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,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

Electronically Delivered

June 21, 2023

Licensee
Eagle Crest Arbor
2955 Lincoln Drive
Roseville, MN 55113

RE: Project Number(s) SL24032015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 25, 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.

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).

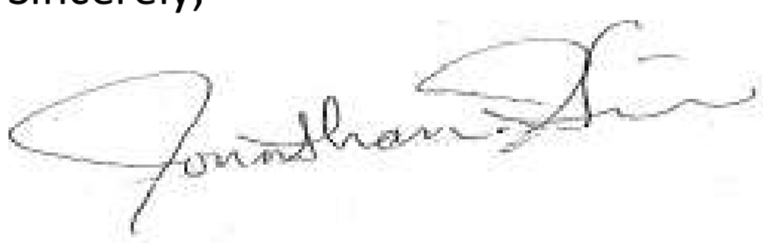
Please address your cover letter for reconsideration requests to:

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,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE CREST ARBOR	2955 LINCOLN DRIVE ROSEVILLE, MN 55113

(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: SL24032015 On May 22, 2023, through May 25, 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 127 active residents; 124 were receiving services under the Assisted Living/Dementia Care 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 with Dementia Care license providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 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 May 23, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of	0 730		

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0 730	Continued From page 2 the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or	0 730		

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0 730	Continued From page 3 status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for four of six residents (R2, R3, R4, 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) 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: R2, R3, R4 and R7's medical records lacked documentation of services received. R2 R2's service plan signed March 29, 2022, indicated R2 received services for medication administration, bathing, extensive morning and evening cares, transfers, escorts, meal, and toileting assistance. R2's service record for May 7, 2023, through May 23, 2023, included, but was not limited to, the following scheduled services: appointment reminder, shower assist with mechanical lift, unlimited escorts, toileting, transfer assist with mechanical lift, meal assistance, reassurance checks, "extensive am assist and extensive pm assist," laundry, compression socks, and medication administration. R2's service record lacked the following	0 730		

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0 730	Continued From page 4 documentation between May 7, 2023 through May 23, 2023: -5 scheduled services for appointment reminder; May 7-10, 2023, May 13, 2023; -1 scheduled service for shower assist; May 10, 2023; -2 scheduled services for unlimited escorts; May 10, 2023; -4 scheduled services for toileting; May 10, 2023, May 13, 2023; -4 scheduled services for transfer assist; May 10, 2023, May 13, 2023; -3 scheduled services for meal assistance; May 10, 2023, May 13, 2023; -1 scheduled service for reassurance checks; May 13, 2023; -1 scheduled service for "extensive am assist;" May 10, 2023; -1 scheduled service for "extensive pm assist;" May 13, 2023; -1 scheduled service for laundry; May 13, 2023; -1 scheduled service for compression socks; May 13 2023; and -1 scheduled service for medication administration; May 20, 2023 R3 R3's service plan signed November 11, 2022, indicated R3 received services for medication administration, bathing, extensive morning and evening cares, laundry, housekeeping, transfer assistance, bed mobility, escorts, meal, and toileting assistance. R3's service record for May 7, 2023, through May 23, 2023, included, but was not limited to, the following scheduled services: appointment reminder, shower assist with mechanical lift, unlimited escorts, toileting, transfer assist with mechanical lift, meal assistance, reassurance	0 730		

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0 730	Continued From page 5 checks, "extensive am assist and extensive pm assist," laundry, compression socks, and medication administration. R3's service record lacked the following documentation on May 10, 2023: -1 scheduled service for bed mobility; -1 scheduled service for "extensive am assist;" -2 scheduled services for transfer assist; -1 scheduled service for homemaking; -1 scheduled service for escort; -2 scheduled services for meal plate set up; and -1 scheduled service for reassurance check R4 R4's service plan, signed March 24, 2022, indicated R4 received services for medication management, extensive morning and evening cares, sensory/communication, shower and toileting assistance, escorts, snacks, housekeeping, and laundry. R4's service record for April 30, 2023, through May 23, 2023, included, but was not limited to, the following scheduled services: sensory, shower assist, unlimited escorts, toileting, meal assistance, reassurance checks, "extensive am assist and extensive pm assist," homemaking, linen change, snack/fluids and compression socks. R4's service record lacked the following documentation between April 30, 2023, through May 23, 2023: -4 scheduled services for sensory; April 1, 2023, May 9, 2023, May 13, 2023, and May 15, 2023; -2 scheduled services for shower assist; April 30, 2023 and May 7, 2023; -9 scheduled services for unlimited escorts; April 30, 2023, May 9, 2023, May 11, 2023, and May 13-15, 2023; -13 scheduled services for toileting; April 30,	0 730		

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0 730	Continued From page 6 2023, May 6-7, 2023, May 9, 2023, May 13-15, 2023, and May 22, 2023; -4 scheduled services for reassurance checks; May 6-7, 2023, May 12, 2023, and May 22, 2023; -3 scheduled services for "extensive am assist"; April 30, 2023, May 9, 2023, and May 15, 2023; -4 scheduled services for "extensive pm assist"; May 13-14, 2023; -3 scheduled services for homemaking; April 30, 2023, May 9, 2023, and May 15, 2023; -2 scheduled services for linen change; April 30, 2023 and May 7, 2023; -5 scheduled services for compression socks; April 30, 2023, May 9, 2023, May 13, 2023, and May 15, 2023; -4 scheduled services for snacks/fluids; May 8, 2023 and May 12-14, 2023; and -1 scheduled service for laundry; May 15, 2023 R7 R7's service plan, dated December 21, 2022, indicated R7 received services for assistance with medication administration, oxygen management, incontinent cares, "extensive am assist and extensive pm assist," showers, transfers, escorts, homemaking, and laundry. R7's service record for April 9, 2023, through May 23, 2023, included, but was not limited to, the following scheduled services: oxygen management, "extensive am assist and extensive pm assist," homemaking, laundry, and showers. R7's service record lacked the following documentation between April 9, 2023, through May 23, 2023: -3 scheduled services for oxygen management; April 9, 2023, April 15, 2023, and May 18, 2023; -3 scheduled services for homemaking; April 17, 2023, April 23, 2023, May 7, 2023; -3 scheduled services for laundry; April 28, 2023,	0 730		

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0 730	Continued From page 7 May 4, 2023, May 5, 2023; -3 scheduled services for "extensive am assist;" April 17, 2023, April 23, 2023, May 7, 2023; -3 scheduled services for "extensive pm assist;" April 16, and April 30, 2023, May 13, 2023; and -1 scheduled service for shower assist, May 5, 2023. On May 24, 2023, at 2:25 p.m., clinical nurse specialist (CNS)-B acknowledged the caregiver services documentation for R2, R3, R4 and R7 were missing areas of documentation. CNS-B also indicated that the employees are trained to document a reason if a service was not completed. In addition, CNS-B stated they were in the process of transitioning to electronic medical record for service documentation. The licensee's MN AL Resident Record policy dated March 16, 2023, included, "The resident record will contain: Documentation that services have been provided as identified in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used	0 780		

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0 780	Continued From page 8 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 provide smoke alarms in building 2945 on the one and two bedrooms apartments and ensure smoke alarms are interconnected so that the actuation of one alarm causes all alarms in the dwelling to actuate as required-this potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include the following:	0 780		

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0 780	Continued From page 9 On 05/24/2023, between 0900 and 1100, survey staff toured the facility with LALD-A and LALD-L. During the facility tour, survey staff observed the facility failed to install smoke alarms in all 1 and 2 bedroom apartment and need to be interconnected per unit in building 2945 LALD-A and LALD-L verbally confirmed survey staff observations during the facility tour. LALD-L stated they would look into it. No further information was provided. Period FOR CORRECTION: Twenty-one (21) 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 ensure the installation and maintenance of portable fire extinguishers at the facility. This	0 790		

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0 790	Continued From page 10 violation could 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). It 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 residents). The findings include the following: 05/24/2023, from 0900 to 1100, survey staff toured the facility with LALD-A and LALD-L. During the facility tour, survey staff observed that the facility failed to maintain the fire extinguishers annually in 2645 and 2955 buildings. LALD-A and LALD-L verbally confirmed survey staff observations during the facility tour. No further information was provided. Period FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=D	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.	0 800		

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0 800	Continued From page 11 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 residents' health, safety, and well-being. This could affect all residents, staff, and visitors directly. 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). It 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 residents). The findings include the following: 05/24/2023, from 0900 to 1100, survey staff toured the facility with LALD-A and LALD-L. During the facility tour, survey staff observed the facility failed to maintain smoke barrier doors by unit 21 in building 2955. LALD-A verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	0 970		

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	24032	A. BUILDING: _____ B. WING _____	05/25/2023

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0 970	Continued From page 12 liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure the contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect 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). Findings include: On May 22, 2023, at 10:20 a.m.., during the entrance conference, a copy of the the facility's contract was requested. The licensee's contract titled Residency Agreement, with a revision date of October 1, 2022, included the following in section 7, page 15-16, waiving the licensee's liability for safety of the resident and their property. The residency agreement included, "Be responsible for the costs associated with the following, caused by the acts or failure of Resident, pets, Resident's agents,	0 970		

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0 970	Continued From page 13 family members, or guests, whether intentional or unintentional, and whether or not under Resident's control or direction: 1) any loss, property damage, or repair or service (including plumbing problems) or injury to any person." On May 24, 2023 at 10:00 a.m., licensed assisted living director (LALD)-A stated, the residency agreements that were provided to the residents were created by the licensee's corporate office. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620		

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01620	Continued From page 14 long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) included an assistive device in the most recent comprehensive assessment for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 May 23, 2023, at 9:20 a.m., surveyor entered R3's room and observed a black metal chair assist device inserted into R3's upholstered chair. A physical therapist (PT) from Optage entered the room minutes later. Surveyor asked PT about the metal chair assist and PT was unsure where it came from but felt it helped R3 get out of the chair safely eighty five percent of the time. The other fifteen percent was not safe due to resident using the four-wheeled walker (4WW) to pull herself up instead of using the handles of the chair assist. On May 23, 2023, throughout the day, surveyor observed R3 walking independently throughout	01620		

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01620	Continued From page 15 the unit with and without her 4WW. On May 23, 2023, at 3:36 p.m., surveyor observed R3 sitting in her upholstered chair. During conversation, R3 was pleasantly confused but indicated she did use the chair riser. R3's diagnoses included age related cognitive decline, falls, hearing loss, and chronic vertigo (dizziness). R3's Service Plan-Attachment E to Residency Agreement signed November 11, 2022, indicated R3 received medication administration, assistance with morning and evening (AM, PM) cares, bathing, toileting, escorts, housekeeping, and laundry. R3's medical record included Progress Notes by an in-house visiting nurse practitioner (NP) dated May 2, 2023, indicated R3 was seen for reports of recent falls and dizziness. Additionally, NP indicated R3 had a history of advanced dementia and had problems lately with moving from bed to a chair. R3's Assessment As of Date completed by an RN on May 18, 2023, lacked an assessment on the Chair Lift Assist device. During interview on May 23, 2023, at 11:55 a.m., RN-F was unsure when the assistive device was installed. RN-F and surveyor both observed a progress note in R3's medical record which indicated the son purchased the assistive device on or around April 5, 2023, based on PT's recommendation. RN-F was unaware that the chair assist device needed to be assessed and documented. RN-F was unable to provide a manufacturer's installation guideline and	01620		

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01620	Continued From page 16 requested that information from the family. RN-F stated whenever they go into R3's room, they glance at the device to make sure it looks appropriate. On May 24, 2023, at 5:17 p.m., through email, RN-F received the manufacturer guideline on the chair assist device by R3's son. The undated User Manual attached under the product guides and documents provides assembly instructions and safety precautions as follows: -regularly check the product to make sure the square bolts and round nuts are secure, -make sure the adjustable legs are always in contact with the floor, -additional safety measures should be taken for users that are a high risk. High risk users include those who are not mentally conscious, or any condition that impair their ability to use the product without assistance, and -if this product is not used properly, serious injury or harm could result. The licensee's Physical Device policy dated June 2018, indicated: "1. The use of any physical device will be reviewed and discussed at or prior to the start of home care, with each clinical review and with the initiation of a new device when facility is made aware. 2. As indicated in the Resident Bill of Rights, residents and/or the resident responsible parties have the ability to choose the equipment and furnishings in their apartment, as defined in the resident lease agreement. [Licensee] and Services Homecare will partner with the resident to determine recommended devices that support the resident's independence and physical	01620		

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01620	Continued From page 17 functioning. The device will be recommended for use based on the manufacturer's recommendations. It is to be noted that [Licensee] and Services Homecare may not be made aware or identify that a physical device has been initiated if the resident elects to add the device without consultation or partnership with the homecare agency. In an effort to support collaboration, an education resource on safety and physical device use will be provided upon admission to each home care client. 3. The resident care plan and vulnerability assessment will be updated to reflect the device to be used. 4. Informed consent for the physical device will be completed by the resident or responsible party. Telephone consent may be obtained when unable to meet with the responsible party. Documentation of the telephone consent will be completed in the form of a clinical note in the resident's medical chart. A copy of the informed consent will be placed in the chart until the original signed consent is returned. 5. [Licensee] and Services Homecare staff will document in the resident's clinical record at the implementation of the device or upon identification of the device by the homecare staff. 6. With changes in condition, the resident's functional use of the device will be assessed. Any changes with the use of the device should be reflected in the resident's care plan and vulnerability assessment. 7. [Licensee] and Services engineering staff will assist residents with the installation on bed assistive devices (that meet FDA requirements) on personal beds only under the following guidelines: a. The resident has been assessed as above for the appropriate use of the device. b. The resident and/or responsible party have	01620		

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01620	Continued From page 18 agreed to the use and installation of the device as intended per manufacturer's recommendations c. The resident and/or responsible party has agreed to pay for the installation and maintenance of the device by the engineering staff. d. The manufacturer's guidelines have been provided to [Licensee] and Services Homecare and engineering staff. 9. [Licensee] and Services therapists and Optage therapists are made aware of these products for referral and purchase. Contracted therapy can be considered for a home safety assessment to make recommendations with a physician's order." No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01620		
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	01640		

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01640	Continued From page 19 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 a written service plan was revised to reflect the current services provided for one of five residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During observation and interview on May 23, 2023, at 11:15 a.m., unlicensed personnel (ULP)-C applied a blue arm brace to R2's right elbow. ULP-C stated the arm brace always went on the right arm but said it would have made more sense to apply it to the left arm to help with contractures. R2's service plan lacked revision to reflect the current treatment plan R2 was receiving. R2's diagnoses included, but were not limited to, vascular dementia, left sided weakness from past polio, frequent falls and gait instability (walking).	01640		

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01640	Continued From page 20 R2's Assessment As Of Date (RN assessment) dated April 19, 2023, indicated resident had left sided weakness and required assistance with applying blue elbow brace, put on while in bed. R2's physician order signed on December 12, 2022, indicated R2 would tolerate wearing elbow orthosis for eight (8) hours without signs and symptoms of redness or pressure areas. R2's service record dated May 7, 2023, through May 13, 2023, indicated under services: Extensive Assist AM at 8:30 a.m., and Extensive Assist PM at 8:30 p.m., "Per family request: Wear LARGE BLUE SPLINT on right arm and the smaller splint on the left arm to keep resident from chewing on her hands." Under service: Wraps inc. w/AM or PM car {care} at 9:00 p.m., "Assistance putting on Blue Elbow Brace. Put on when in bed. 1. Remove Velcro tabs on side of elbow pad. 2. Place brace onto left arm and secure elbow pad. 3. Close Velcro and bicep (upper arm below armpit) and forearm (between elbow and wrist) after tucking in flaps. Look for black marks for attaching." During interview on May 23, 2023, at 11:26 a.m., registered nurse (RN)-F stated the second arm splint was used to help the resident from biting itself, which was ineffective so second splint was discontinued by nursing staff. During interview on May 24, 2023, at 11:56 a.m., RN-F confirmed the service plan was not updated to reflect the discontinuation of second splint. During interview, RN-F updated the service plan. The licensee's MN AL Service Plan Policy dated August 1, 2021 indicated all assisted living	01640		

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01640	Continued From page 21 residents would have an up-to-date service plan identifying services to be provided based on the assessments by the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure medications were stored under proper temperature controls according to manufacturer instructions. This had the potential to affect one resident (R5) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5 had diagnoses to include heart disease and diabetes. R5's service plan, dated January 17,	01880		

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01880	Continued From page 22 2023, indicated R5 received services for assistance with linen change, laundry, "reassurance checks", nail care, blood glucose monitoring, medication and insulin administration. R5's medication administration record (MAR) dated, May 16, 2023, through May 23, 2023, indicated R5 received Novolog 70/30 (a combination of fast acting and long-acting insulin), 45 units (U) every day, before breakfast. On May, 22, 2023, at 1:10 p.m., registered nurse (RN)-E stated all extra unopened insulin was stored in the residents' private refrigerator. In addition, RN-E stated they do not regularly monitor the temperature of the residents' private refrigerators. On May 22, 2023, at 4:10 p.m., unlicensed personnel (ULP)-H was observed to provide blood glucose testing and insulin administration to R5. After blood glucose testing and insulin administration was completed for R5, ULP-H was asked where unopened insulin was stored; ULP-H stated R5's unopened insulin pens were stored in their private refrigerator. R5's refrigerator was observed to contain a locked separate box containing six unopened Novolog 70/30 insulin pens, with expiration date of March 30, 2024. On May 22, 2023, at 4:25 p.m., ULP-H stated they did not monitor the temperature of the residents private refrigerators. The surveyor observed there was no thermometer R5's refrigerator. On May 24, 2023, at 8:45 a.m., clinical nurse specialist (CNS)-B, and licensed assisted living director (LALD)-A stated, the residents'	01880		

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01880	Continued From page 23 refrigerator temperatures were not monitored. CNS-B and LALD-A confirmed unopened insulin pens were stored in the residents' private refrigerators. RN-B stated she understood the need to monitor the temperature regularly. Manufacturer storage instructions for Novolog dated June 2022, indicated, "Unused Pens may be used until the expiration date printed on the label, if kept in the refrigerator at 36°F to 46°F (2°C to 8°C)." The instructions further indicated "Do not freeze Novolog. Do not use Novolog if it has been frozen." The licensee's Assisted Living (AL) Medication Management policy, revised March 6, 2023, indicated, "8. b. All medications will be stored in a locked box in a cabinet or refrigerator in the resident ' s unit in areas in which the temperature may not fluctuate to levels that are unsuitable for medication storage. Medications delivered to the facility for residents needing medication administration will be added to these locked boxes or cabinets at the earliest convenient time and secured until that time. Medications will be given to residents by one of the methods described above, according to the resident ' s assessed needs." In addition, "i. For sites using medication carts: medications are stored in a locked medication cart and the carts are stored in a locked medication room when not in use. Medications delivered to the facility for residents needing medication administration will be added to these locked boxes or cabinets at the earliest convenient time and secured until that time. Medications requiring refrigeration are in a locked medication refrigerator in the locked medication room." No further information was provided.	01880		

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01880	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for a treatment (blue elbow brace) in the resident's record for one of five residents (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	01950		

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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
01950	Continued From page 25 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During observation and interview on May 23, 2023, at 11:15 a.m., after toileting assistance, unlicensed personnel (ULP)-C applied a blue arm brace to R2's right elbow. ULP-C stated the arm brace always went on the right arm but stated it would have made more sense to apply it to the left arm, to help with contractures. R2's diagnoses included, but were not limited to: vascular dementia, left sided weakness from past polio, frequent falls and gait instability (walking). R2's Assessment As Of Date (RN assessment) dated April 19, 2023, indicated resident had left sided weakness and required assistance with applying blue elbow brace, put on while in bed. R2's prescriber order signed on December 12, 2022, indicated R2 would tolerate wearing elbow orthosis for eight (8) hours without signs and symptoms of redness or pressure areas. R2's Service Charting Form-1 week dated from May 7, 2023 to May 13, 2023, indicated under service: "Extensive Assist AM at 8:30 a.m., staff would make sure left arm was straightened and resting on left thigh-do this throughout the day and to wear large blue splint on right arm and the smaller splint on the left arm to keep resident from chewing on her hands."	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE CREST ARBOR	2955 LINCOLN DRIVE ROSEVILLE, MN 55113

(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
01950	Continued From page 26 During interview on May 23, 2023, at 11:26 a.m., registered nurse (RN)-G stated the blue elbow brace was supposed to go on the left arm to assist with contractures. RN-G indicated R2 used to have two elbow braces to help R2 from chewing on her clothing. RN-G stated the brace did not help prevent R2 from chewing so it was only supposed to go on left arm. Surveyor observed RN-G remove the elbow brace from the right arm and placed it on the left arm. The licensee's MN AL Treatment and Therapy Management Policy dated March 7, 2023, indicated licensee would have developed written, specific instruction for each resident. Additionally, the licensee would ensure staff were competency tested by the RN on administration of the treatment and therapy to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE CREST ARBOR	2955 LINCOLN DRIVE ROSEVILLE, MN 55113

(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
01960	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed and failed to document the reason they were not administered and any follow up procedures provided to meet the resident's needs for two of five residents (R2, R4) with treatment and/or therapies. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: INCORRECT ADMINISTRATION During observation on May 23, 2023, at 11:15 a.m., unlicensed personnel (ULP)-C applied a blue arm brace to R2's right elbow. ULP-C was hired by licensee on March 28, 2023. R2's service record dated May 7, 2023, through May 13, 2023, indicated under services: "Extensive Assist AM" at 8:30 a.m., and "Extensive Assist PM" at 8:30 p.m., "Per family request: Wear LARGE BLUE SPLINT on right arm and the smaller splint on the left arm to keep resident from chewing on her hands." Under service: Wraps inc. w/AM or PM car {care} at 9:00 p.m., "Assistance putting on Blue Elbow Brace. Put on when in bed. 1. Remove Velcro tabs on side of elbow pad. 2. Place brace onto	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	05/25/2023

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
01960	Continued From page 28 left arm and secure elbow pad. 3. Close Velcro and bicep (upper arm below armpit) and forearm after tucking in flaps. Look for black marks for attaching." ULP-C's employee training record dated April 19, 2023, indicated ULP-C demonstrated competency on the following: -splints/braces and positioning devices; -specific directions for use and use schedule; -washing schedule; and -monitoring skin integrity On May 23, 2023, at 11:15 a.m., ULP-C stated s/he wasn't sure the purpose of the brace but thought it was for contractures. ULP-C stated s/he always put it on the right arm in the morning after cares but felt it was better to apply it to the left arm due to contractures. During interview and observation on May 23, 2023, at 11:26 a.m., registered nurse (RN)-F indicated the blue brace was supposed to be worn on left arm. RN-F stated R2 used to have two arm braces for dual purposes (prevent biting and contractures) but the right arm brace was not effective in preventing R2 from biting herself. Surveyor then observed RN-F remove the blue arm brace from R2's right arm and placed it on the left arm and proceeded to approach ULP-C and spoke with him/her in private. DOCUMENTATION ERROR R2 R2's service record lacked the following documentation between April 30, 2023, through May 23, 2023: -1 scheduled service for Blue Elbow Brace application at 9:00 p.m.; May 13, 2023.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	05/25/2023

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
01960	Continued From page 29 R4 On May 23, 2023, at 9:35 a.m., ULP-N applied R4's compression stockings to both legs. R4's diagnoses included, but were not limited to mild cognitive impairment, congestive heart failure, chronic obstructive pulmonary disease (COPD), and restless leg syndrome. R4's Assessment As Of Date (RN assessment) dated March 17, 2023, indicated R4 required assistance with compression stockings and blue boot. R4's service record lacked the following documentation between April 30, 2023 through May 23, 2023: -3 scheduled services for compression stocking application; April 30, 2023, May 9, 2023, and May 15, 2023; -2 scheduled services for compression stocking removal and wash; May 12, 2023 and May 15, 2023; -2 scheduled services for blue boot application under "Extensive Assist PM"; May 13, 2023 and May 14, 2023; and -2 scheduled services for blue boot removal under "Extensive Assist AM"; May 9, 2023 and May 15, 2023. During interview on May 23, 2023, at 3:03 p.m., RN-F indicated the missed documentation meant the service was delivered but not documented. The licensee's MN AL Resident Record policy dated March 16, 2023, included, "The resident record will contain: Documentation that services have been provided as identified in the service plan."	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE CREST ARBOR	2955 LINCOLN DRIVE ROSEVILLE, MN 55113

(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
01960	Continued From page 30 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the written or electronically recorded orders included the required information for one of five residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 22, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-B	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	05/25/2023

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
01970	Continued From page 31 confirmed the licensee provided treatment services to the licensee's residents. During observation on May 23, 2023, at 11:15 a.m., unlicensed personnel (ULP)-C applied a blue arm brace to R2's right elbow. R2's diagnoses included, but were not limited to, vascular dementia, left sided weakness from past polio, frequent falls and gait instability (walking). R2's prescriber orders dated December 12, 2022, lacked instruction on frequency, duration, and other information needed to administer the treatments. The order indicated a trial of elbow orthoses while awaiting grip hand splint. The order also indicated the occupational therapist would educate the licensee on donning/doffing (putting on and removing) schedule for orthoses. Additionally, the order did not include the schedule of donning/doffing the splints but indicated R2 would tolerate wearing elbow orthoses for eight (8) hours without signs and symptoms of redness or pressure areas. R2's Service Charting Form-1 week dated May 7, 2023 through May 13, 2023, indicated under services: Extensive Assist AM at 8:30 a.m., and Extensive Assist PM at 8:30 p.m., "Per family request: Wear LARGE BLUE SPLINT on right arm and the smaller splint on the left arm to keep resident from chewing on her hands." Under service: NO CHARGE Ted Assist/Ace Wraps inc. w/AM or PM car {cares} at 9:00 p.m., "Assistance putting on Blue Elbow Brace. Put on when in bed. 1. Remove Velcro tabs on side of elbow pad. 2. Place brace onto left arm and secure elbow pad. 3. Close Velcro and bicep (upper arm below armpit) and forearm after tucking in flaps. Look for black marks for attaching."	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01970	Continued From page 32 R2's medical record lacked provider orders to discontinue the second arm splint and hand splint. During interview on May 24, 2023, at 11:56 a.m., registered nurse (RN)-F indicated the only orders available for the splints were already provided to surveyor. RN-F also indicated there were no orders to discontinue the second arm splint and hand splint. On May 23, 2023, at 11:15 a.m., ULP-C stated s/he wasn't sure what the purpose of the brace but thought it was for contractures. ULP-C stated s/he always put it on the right arm in the morning after cares but felt it was better to apply it to the left arm due to contractures. The licensee's MN AL Treatment and Therapy Management Policy updated on March 7, 2023, indicated the licensee would obtain order from the medical provider and update the care plan and service plan. Additionally, the licensee would communicate the new service (s) to the resident assistants {ULPs} minimally by documenting in the care plan and resident's services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Type: Full
Date: *05/23/23*
Time: 12:15:00
Report: 1025231129

Food and Beverage Establishment Inspection Report

Location:
Eagle Crest Arbor
2955 Lincoln Drive
Roseville, MN55113
Ramsey County, 62

Establishment Info:
ID #: 0037648
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6516283000
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.

5-200A Plumbing: approved materials/design

5-203.11A ***** Priority 2 *****

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.

In the event of a remodel or major change to the kitchen, provide a handwashing sink within convenient distance of the clean side of the dishing area.

Comply By: 05/23/23

Surface and Equipment Sanitizers

"Sink & Surface" DDBSA: = OK at Degrees Fahrenheit
Location: 3 compartment sink
Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit
Location: Kitchen 160 W 180 R
Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit
Location: Chickadee
Violation Issued: No

Hot Water: = at 164 Degrees Fahrenheit
Location: Marigold
Violation Issued: No

Hot Water: = at 167 Degrees Fahrenheit
Location: Woodland
Violation Issued: No

Type: Full
Date: *05/23/23*
Time: 12:15:00
Report: 1025231129
Eagle Crest Arbor

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cheese, pkg
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Butter
Temperature: 41 Degrees Fahrenheit - Location: Server expo main kitchen
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Server expo main kitchen
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Server expo upright
Violation Issued: No

Process/Item: Sour cream
Temperature: 49 Degrees Fahrenheit - Location: Rear prep cooler upright
Violation Issued: No

Process/Item: Chicken salad
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Chickadee cooler
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Marigold cooler
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Woodland cooler
Violation Issued: No

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

Employee health and hygiene, employee beverage, equipment. Discussed no TPHC in use (in-use utensils e.g. ice cream every 4 hours), no animal food served raw or undercooked, all eggs Pasteurized; discussed date marking system, chemical use in neighborhood kitchen (housekeeping vs culinary; sink use in neighborhood kitchen, convenient and ergonomic for handwashing sinks); receiving, pest control, lighting, composting (bins returned clean), equipment cleaning (e.g. ice makers).

Type: Full
Date: *05/23/23*
Time: 12:15:00
Report: 1025231129
Eagle Crest Arbor

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 Minnesota Department of Health inspection report number 1025231129 of 05/23/23.

Certified Food Protection Manager: Mary Kieffer

Certification Number: FM107496 Expires: 08/26/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231129

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 05/23/23
Time In 12:15:00
Time Out

Establishment	Address	City/State	Zip Code	Telephone
Eagle Crest Arbor	2955 Lincoln Drive	Roseville, MN	55113	6516283000

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037648		Full		

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		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) Mary Lyon **Date:** 05/23/23

Inspector (Signature) Cory Kirk