Electronically Delivered

September 12, 2022

Administrator
HealthPoint HWS @ 93rd
351 93rd Avenue Northeast
Blaine, MN 55434

RE: Project Number(s) SL34173015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 12, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for 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 . . ."

**IMPOSITION OF FINES**
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**

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

**DOCUMENTATION OF ACTION TO COMPLY**
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the 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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34173 | A. BUILDING: _____ B. WING _____ | 08/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HEALTHPOINT HWS @ 93RD | 351 93RD AVENUE NE BLAINE, MN 55434 |

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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL#34173015<br><br>On August 8, 2022, through August 9, 2022, 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 three residents, receiving services under the provider's Assisted Living with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 470 SS=F | 144G.41 Subdivision 1 Minimum requirements | 0 470 | | |

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| 0 470 | Continued From page 1<br>(11) develop and implement a staffing plan for determining its staffing level that:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;<br>(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:<br>(i) awake;<br>(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;<br>(iii) capable of communicating with residents;<br>(iv) capable of providing or summoning the appropriate assistance; and<br>(v) capable of following directions;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the staffing plan was developed and posted as required. This had the potential to affect all residents, staff, and visitors to the licensee.<br><br>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 | 0 470 | | |

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| 0 470 | Continued From page 2<br>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).<br><br>The findings include:<br><br>On August 8, 2022, at approximately 11:30 a.m., the surveyor toured the licensee's building, and observed postings that included an expired assisted living license with dementia care, the assisted living director's license and menu, but the staffing plan was missing.<br><br>The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following:<br>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;<br>(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and<br>(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility.<br><br>On August 8, 2022, at approximately 3:00 p.m., registered nurse (RN)-C acknowledged the staffing plan had not been developed to address the content listed above, and stated the licensee will post it soon.<br><br>The licensee's Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse | 0 470 | | |

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| 0 470 | Continued From page 3<br>supervisor will develop and implement a written plan that provides an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven days a week.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 470 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(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:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents of the facility. | 0 480 | | |

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| 0 480 | Continued From page 4<br><br>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).<br><br>The findings include:<br><br>Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated August 8, 2022.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 490 SS=F | 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements<br><br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br>(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance;<br>(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;<br>(vi) provide culturally sensitive programs; and | 0 490 | | |

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| 0 490 | Continued From page 5<br>(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect the licensee's three current residents.<br><br>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 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).<br><br>The findings include:<br><br>On August 8, 2022, at approximately 12:15 p.m., registered nurse (RN)-C confirmed an activity program had not been developed with the required content. In addition, RN-C stated the licensee had stopped all activities due to COVID-19 pandemic, and they were planning to revive the activities program again. | 0 490 | | |

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| 0 490 | Continued From page 6<br><br>The licensee's Activity Programming policy dated August 1, 2021, indicated the licensee will provide a wide range of activities and social recreation for its residents. This programming will provide opportunities for residents and staff engagement.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 490 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(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.<br>(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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19 when the licensee failed to ensure staff and visitors entering or re-entering the building were screened for COVID-19 with documented temperatures and symptom screening questions. This had the potential to | 0 510 | | |

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| 0 510 | Continued From page 7<br>affect all three residents, staff, and visitors at the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The Minnesota Department of Health (MDH) document titled COVID-19 Toolkit - Information for Long Term Care Facilities dated March 8, 2021, indicated that health screening should be conducted for other essential health care personnel including, but not limited to, state surveyors.<br><br>Upon entrance to the licensee's establishment on August 8, 2022, at approximately 9:30 a.m., the state surveyor was not screened for signs and symptoms of COVID-19.<br><br>On August 8, 2022, at approximately 9:35 a.m., the surveyor observed by the licensee's facility main entrance a screening station with hand sanitizer, but it lacked a screening tool and thermometer.<br><br>On August 8, 2022, at approximately 11:00 a.m., registered nurse (RN)-C arrived at the licensee's establishment and was not screened for COVID-19 symptoms.<br><br>On August 8, 2022, at approximately 11:10 a.m., | 0 510 | | |

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| 0 510 | Continued From page 8<br><br>RN-A arrived at the licensee's establishment and was not screened for COVID-19 symptoms.<br><br>On August 8, 2022, at approximately 11:25 a.m., office manager (OM)-D arrived at the licensee's establishment and was not screened for COVID-19 symptoms.<br><br>On August 8, at approximately 1:20 p.m., a state environmental health surveyor entered the facility and was not screened for COVID-19 symptoms.<br><br>On August 9, 2022, at approximately 12:30 p.m., RN-C acknowledged all the above missed screening when they arrived at the licensee's establishment. In addition, RN-C stated everyone entering is screened and provided an employee screening log but the licensee lacked a visitors screening log.<br><br>The licensee's Infection Control policy dated August 1, 2021, indicated the licensee will screen residents, staff and all visitors entering the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 570 SS=C | 144G.42 Subdivision 1 Display of license<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document | 0 570 | | |

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| 0 570 | Continued From page 9<br><br>review, the licensee failed to post its current Assisted Living Facility with Dementia Care (ALFDC) license with the Minnesota Department of Health (MDH). This had the potential to affect all residents, staff, and visitors to the licensee.<br><br>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 the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On August 8, 2022, at approximately 9:00 a.m., in licensee's main entrance hall, the surveyor observed a license displayed on the wall that expired on July 31, 2022.<br><br>On August 8, 2022, at approximately 11:40 a.m., during the entrance conference, registered nurse (RN)-C and office manager (OM)-D acknowledged the posted license was expired and stated the license was renewed but not displayed. In addition, OM-D stated the licensee will provide the new license to surveyor before day ended.<br><br>No further information provided<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 570 | | |
| 0 580 SS=F | 144G.42 Subd. 2 Quality management<br><br>The facility shall engage in quality management | 0 580 | | |

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| 0 580 | Continued From page 10<br>appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to engage in and maintain documentation of a quality management activity. This had the potential to affect all residents receiving assisted living services.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On August 8, 2022, at approximately 11:45 a.m., during the entrance conference with registered nurse (RN)-A and RN-C, the surveyor requested to review documentation of the licensee's quality management activities. RN-C stated the licensee had a quality management plan. | 0 580 | | |

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| 0 580 | Continued From page 11<br><br>On August 8, 2022, at approximately 1:45 p.m., RN-C provided the surveyor with the licensee's quality management policy.<br><br>On August 8, 2022, at approximately 1:47 p.m., RN-C acknowledged the licensee did not have a quality management plan as earlier stated.<br><br>The licensee's undated Quality Management Project policy indicated the licensee will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 580 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or | 0 780 | | |

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| 0 780 | Continued From page 12<br>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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms on each level and in the immediate vicinity of each sleeping room, and failed to ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On August 9, 2022, between 10:15 a.m. and 11:15 a.m., survey staff toured the facility with the office manager (OM)-D. During the facility tour, survey staff observed the following:<br><br>1. There was no smoke alarm in the upstairs office area.<br>2. The smoke alarm outside Bedroom A was not | 0 780 | | |

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| 0 780 | Continued From page 13<br>interconnected.<br>3. There was no smoke alarm in the immediate vicinity of the sleeping area where Bedroom B and Bedroom C were located.<br><br>OM-D verbally confirmed survey staff observations during the facility tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected | 0 800 | | |

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| 0 800 | Continued From page 14<br>or has the potential to affect a large portion or all residents).<br><br>The findings include:<br><br>On August 9, 2022, between 10:15 a.m. and 11:15 a.m., survey staff toured the facility with the office manager (OM)-D. During the facility tour, survey staff observed the following:<br><br>1. The bathroom exhaust fan on the main level was covered in lint and dust.<br>2. Bedroom C had a damaged window screen.<br>3. The basement bedroom light switch was broken, the vent frill was missing and the egress window did not have a ladder.<br>4. The convenience ramp in the living room was not secured in place causing a potentially worse tripping hazard than was already existing.<br><br>OM-D verbally confirmed survey staff observations during the facility tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for | 0 810 | | |

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| 0 810 | Continued From page 15<br>residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain fire safety and evacuation plans and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility.<br><br>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 | 0 810 | | |

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| 0 810 | Continued From page 16<br>problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).<br><br>The findings include:<br><br>During interview on August 9, 2022, at 11:15 a.m., the office manager (OM)-D stated they were doing staff training at the same time as they were performing the evacuation drills. Survey staff recommended separating the training from the drills. OM-D also stated that none of the residents were capable of assisting in their own evacuation so they were not offering any training to residents at that time.<br><br>Review of the fire policy showed the following:<br><br>1. Drills completed 08/10/2021, 09/28/2021, 10/05/2021, 10/15/2021, 10/29/2021, 12/20/2021, 02/23/2022, and 04/20/2022. No evacuation drills recorded or scheduled since April 20, 2022. Missing completed drill from June and no completed or scheduled drill for August. Per the interview, staff training happened on the same days as the evacuation drills.<br><br>2. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar emergency. No written instructions for addressing any unique situation during an evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation. The policy was a basic policy from a third-party provider and had not been edited or updated to fit the facility.<br><br>No further information was provided. | 0 810 | | |

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| 0 810 | Continued From page 17<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 970 SS=C | 144.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all three residents.<br><br>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 the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On August 8, 2022, at approximately 1:20 p.m., registered nurse (RN)-C provided a blank Assisted Living Contract and indicated the contract was used by the licensee for all residents | 0 970 | | |

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| 0 970 | Continued From page 18<br>who received services.<br><br>The Assisted Living Contract included sections titled Miscellaneous Provisions, Insurance Liability and Release. The section indicated the resident waived liability (responsibility) of the licensee for the health and safety or personal property of a resident. The Indemnification section stated the resident will hold harmless the provider, its employees, and agents from and against any loss, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident.<br><br>On August 8, 2022, at approximately 4:15 p.m., registered nurse (RN)-C acknowledged the contract required residents to waive the licensee's liability for health, safety, or personal property.<br><br>The licensee's Signing an Assisted Living Contract policy dated August 1, 2021, indicated prospective resident will sign contract at move in. The policy lacked verbiage to include waiving of rights.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01370 SS=D | 144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn<br><br>(a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services | 01370 | | |

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| 01370 | Continued From page 19<br>provided;<br>(2) reports of changes in the resident's condition to the supervisor designated by the facility;<br>(3) basic infection control, including blood-borne pathogens;<br>(4) maintenance of a clean and safe environment;<br>(5) appropriate and safe techniques in personal hygiene and grooming, including:<br>(i) hair care and bathing;<br>(ii) care of teeth, gums, and oral prosthetic devices;<br>(iii) care and use of hearing aids; and<br>(iv) dressing and assisting with toileting;<br>(6) training on the prevention of falls;<br>(7) standby assistance techniques and how to perform them;<br>(8) medication, exercise, and treatment reminders;<br>(9) basic nutrition, meal preparation, food safety, and assistance with eating;<br>(10) preparation of modified diets as ordered by a licensed health professional;<br>(11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;<br>(12) awareness of confidentiality and privacy;<br>(13) understanding appropriate boundaries between staff and residents and the resident's family;<br>(14) procedures to use in handling various emergency situations; and<br>(15) awareness of commonly used health technology equipment and assistive devices.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure training and | 01370 | | |

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| 01370 | Continued From page 20<br>competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel ((ULP)-B) with records reviewed.<br><br>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).<br><br>The findings include:<br><br>ULP-B was hired on May 20, 2020, to provide comprehensive home care services and started providing assisted living services on August 1, 2021.<br><br>On August 8, 2022, at approximately 1:11 p.m., ULP-B administered noon medications to R4.<br><br>ULP-B's employee records lacked evidence of completed training and competency evaluation to include the following topics:<br>- reports of changes in the resident's condition to the supervisor designated by the licensee<br>- basic nutrition, meal preparation, food safety, and assistance with eating<br>- preparation of modified diets as ordered by a licensed health professional<br>- communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family<br>- awareness of confidentiality and privacy<br>- understanding appropriate boundaries between staff and residents and the resident's family | 01370 | | |

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| 01370 | Continued From page 21<br>- procedures to utilize in handling various emergency situations<br>- awareness of commonly used health technology equipment and assistive devices<br><br>On August 9, 2022, at approximately 10:40 a.m., registered nurse (RN)-C acknowledged ULP-B's employee record was missing the required training and competency evaluation. In addition, RN-C stated the licensee was not aware ULP-B's training record was missing and will ensure the training is completed.<br><br>The licensee's Employee General Orientation policy dated August 1, 2021, indicated upon hire and prior to performing any functions of their position, each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. The policy lacked verbiage to include training and competency evaluations.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01370 | | |
| 01380 SS=D | 144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn<br><br>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:<br>(1) observing, reporting, and documenting resident status;<br>(2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; | 01380 | | |

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| 01380 | Continued From page 22<br>(3) reading and recording temperature, pulse, and respirations of the resident;<br>(4) recognizing physical, emotional, cognitive, and developmental needs of the resident;<br>(5) safe transfer techniques and ambulation;<br>(6) range of motioning and positioning; and<br>(7) administering medications or treatments as required.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel ((ULP)-B) with records reviewed.<br><br>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).<br><br>The findings include:<br><br>ULP-B was hired on May 20, 2020, to provide comprehensive home care services and started providing assisted living services on August 1, 2021.<br><br>On August 8, 2022, at approximately 1:11 p.m., ULP-B administered noon medications to R4.<br><br>ULP-B's employee records lacked evidence of completed training and competency evaluation to include the following topics: | 01380 | | |

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| 01380 | Continued From page 23<br>- observation, reporting, and documenting of resident status<br>- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel<br>- recognizing physical, emotional, cognitive, and developmental needs of the resident<br>- range of motioning and positioning<br><br>On August 9, 2022, at approximately 10:40 a.m., registered nurse (RN)-C acknowledged ULP-B's employee record was missing the required training and competency evaluation. In addition, RN-C stated the licensee was not aware ULP-B's training record was missing and will ensure the training is completed.<br><br>The licensee's Employee General Orientation policy dated August 1, 2021, indicated upon hire and prior to performing any functions of their position, each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure. The policy lacked verbiage to include training and competency evaluations.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01380 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's | 01470 | | |

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| 01470 | Continued From page 24<br>policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation 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:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and | 01470 | | |

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| 01470 | Continued From page 25<br><br>the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations for one of two employees (unlicensed personnel (ULP)-B) with employee records reviewed.<br><br>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).<br><br>The findings include:<br><br>ULP-B started employment with licensee on May 20, 2020, under the comprehensive home care license and started providing assisted living services August 1, 2021.<br><br>On August 8, 2022, at approximately 1:11 p.m., ULP-B administered noon medications to R4. | 01470 | | |

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| 01470 | Continued From page 26<br><br>ULP-B's employee file lacked orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents to include the following topics:<br>- Overview of assisted living statutes<br>- Review of provider's policies and procedures<br>- Assisted living bill of rights<br>- Assisted living services the employee will provide and provider's scope of license<br>- Principles of person-centered planning/service delivery<br><br>On August 9, 2022, at approximately 10:40 a.m., registered nurse (RN)-C acknowledged ULP-B's employee record was missing orientation to assisted living facility licensing requirements and regulations as required. In addition, RN-C stated the licensee was not aware ULP-B's orientation record was missing and will ensure the training is completed.<br><br>The licensee's Employee General Orientation policy dated August 1, 2021, indicated upon hire and prior to performing any functions of their position, each new employee and volunteer will be oriented in accordance with State and Federal regulations, as well as company policy and procedure.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01500 SS=D | 144G.63 Subd. 5 Required annual training | 01500 | | |

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| 01500 | Continued From page 27<br>(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 training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(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;<br>(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;<br>(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<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(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 | 01500 | | |

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| 01500 | Continued From page 28 | 01500 | | |

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;
(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 interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-B) with employee records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

ULP-B started employment on May 20, 2020, under the comprehensive home care license and began providing assisted living services on

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| 01500 | Continued From page 29<br>August 1, 2021.<br><br>On August 8, 2022, at approximately 1:11 p.m., ULP-B administered noon medications to R4.<br><br>ULP-B's record lacked evidence of annual training to include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(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;<br>(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;<br>(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<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(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 | 01500 | | |

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| 01500 | Continued From page 30<br>include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>On August 9, 2022, at approximately 11:40 a.m., registered nurse (RN)-C acknowledged ULP-B's employee record was missing the required annual training. In addition, RN-C stated the licensee was not aware ULP-B's annual training record was missing and will ensure the training is completed as required.<br><br>The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff that perform direct care services will complete at least eight (8) hours of annual training for each 12 months of employment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01500 | | |
| 01540 SS=F | 144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED<br><br>(3) for assisted living facilities with dementia care, | 01540 | | |

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| 01540 | Continued From page 31<br>direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for two of two employees (licensed assisted living director (LALD)-E, unlicensed personnel (ULP)-B) with records reviewed.<br><br>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).<br><br>The findings include:<br><br>The licensee had a current assisted living facility | 01540 | | |

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| 01540 | Continued From page 32<br>with dementia care (ALFDC) license effective August 1, 2022.<br><br>LALD-E started employment with licensee on September 22, 2021.<br><br>LALD-E's employee training record indicated four (4) hours of dementia care training completed on January 6, 2021. LALD-E's employee record lacked the required dementia care training of at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date.<br><br>ULP-B had a hire date of May 20, 2020, under the comprehensive home care license and started providing assisted living services to licensee's residents on August 1, 2021.<br><br>ULP-B's employee training record indicated five and one half (5.5) hours of dementia care training completed on February 19, 2021. ULP-B's employee record lacked the required dementia care training of at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date.<br><br>On August 9, 2022, at approximately 12:21 p.m., registered nurse (RN)-C acknowledged LALD-E and ULP-B had not completed the initial required hours of dementia care training within the required time frame and before providing direct care services to licensee's residents. In addition, RN-C stated the licensee had not updated all employee records to reflect the current training requirement.<br><br>The licensee's Notice of Dementia Training policy dated August 1, 2021, indicated the licensee will | 01540 | | |

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| 01540 | Continued From page 33<br>make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The policy lacked verbiage on required hours and timing for dementia training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01540 | | |
| 01690 SS=E | 144G.71 Subdivision 1 Medication management services<br><br>(a) This section applies only to assisted living facilities that provide medication management services.<br>(b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.<br>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and | 01690 | | |

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| 01690 | Continued From page 34<br>designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to implement and maintain current medication management (controlled substance) policy and procedures developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines for two of two residents (R1, R3) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>R1 was admitted to the licensee April 15, 2020.<br><br>R1's service plan dated August 1, 2021, indicated R1 received services to include medication management, diabetic foot care, blood glucose monitoring, grooming and meal assistance. | 01690 | | |

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| 01690 | Continued From page 35<br><br>On August 9, 2022, at approximately 8:40 a.m., ULP-F prepared and administered morning medications to R1.<br><br>On August 9, 2022, at approximately 9:30 a.m., the surveyor observed R1's controlled medication storage area. R1 was prescribed hydrocodone-acetaminophen 5-325 milligram (mg) 1-2 tablets by mouth every four hours as needed. R1's controlled substance records indicated there were 23 tablets remaining, but when the RN-A physically counted the tablets, there were 21 tablets remaining in the bottle.<br><br>R3 was admitted to the licensee June 6, 2019.<br><br>R3's service plan dated August 1, 2021, indicated R1 received services to include medication management, blood glucose monitoring, nail/foot care, insulin administration, and meal assistance.<br><br>On August 9, 2022, at approximately 9:30 a.m., the surveyor observed R3's controlled medication storage area. R3 was prescribed diazepam 5 mg tablets take one tablet by mouth twice a day as needed. R3's controlled substance records indicated there were four tablets remaining, but when the RN-A physically counted the tablets, there were nine tablets remaining in the bottle.<br><br>On August 9, 2022, at approximately 10:20 a.m., RN-C acknowledged the findings above and stated the licensee will correct the anomaly. In addition, RN-C stated ULPs will need a retraining to refresh the counting skill and documenting requirements after administration.<br><br>No further information was provided. | 01690 | | |

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|---|---|---|---|---|
| 01690 | Continued From page 36<br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01690 | | |
| 01890 SS=E | 144G.71 Subd. 20 Prescription drugs<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to dispose of expired medications and ensure time sensitive medications were dated and labeled correctly for two of three residents (R1, R3) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>R1 was admitted to the licensee on April 15, 2020.<br><br>R1's service plan dated August 1, 2021, indicated R1 received services to include medication management, diabetic foot care, blood glucose | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34173 | A. BUILDING: _____ B. WING _____ | 08/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEALTHPOINT HWS @ 93RD | 351 93RD AVENUE NE BLAINE, MN 55434 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 37<br>monitoring, grooming and meal assistance.<br><br>On August 9, 2022, at approximately 8:40 a.m., ULP-F prepared and administered morning medications to R1.<br><br>On August 9, 2022, at approximately 9:30 a.m., the surveyor observed R1's medication storage area and noted the following expired medications:<br>- Novolog Flexpen 100 units/milliliter (ml) injection expired February 17, 2022<br>- hydroxyzine 25 milligram (mg) 1-2 capsules by mouth three times a day as needed expired September 24, 2021<br><br>R3 was admitted to the licensee on June 6, 2019.<br><br>R3's service plan dated August 1, 2021, indicated R1 received services to include medication management, blood glucose monitoring, nail/foot care, insulin administration, and meal assistance.<br><br>On August 9, 2022, at approximately 9:30 a.m., the surveyor observed R3's medication storage area and noted the following time sensitive medications lacked open dates and labels:<br>- Novolog Flexpen 100 units/ml<br>- Victoza injection<br><br>On August 9, 2022, at approximately 10:20 a.m., registered nurse (RN)-C acknowledged the findings above and stated the licensee will correct the anomaly.<br><br>The licensee's Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated that prior to providing medication management services, the licensee will have a registered nurse conduct an assessment to determine what medication | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01890 | Continued From page 38<br>management services will be provided and how the services will be provided. The policy lacked verbiage to include labeling, and handling of expired medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(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 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.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to document in the resident's record the disposition of medication to include | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 34173 | A. BUILDING: _____ B. WING _____ | 08/12/2022 |

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|---|---|---|---|---|
| 01910 | Continued From page 39<br>required content for one of one discharged resident (R2) with record reviewed.<br><br>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).<br><br>The findings include:<br><br>R2 was discharged from the licensee on February 28, 2022.<br><br>R2's Service Plan dated August 1, 2021, indicated R2 received services which included medication administration, comprehensive assessment, and supervision.<br><br>R2's provider orders dated October 25, 2021, indicated R2 was receiving the following medications:<br>- amlodipine 5 milligram (mg) tablet daily by mouth,<br>- atorvastatin 40 mg tablet at bedtime,<br>- furosemide 20 mg tablet every morning,<br>- losartan 25 mg tablet take one half (1/2) tablet once daily,<br>- metformin 500 mg tablet take two tablets two times daily,<br>- metoprolol 25 mg tablet daily in the morning,<br>- olanzapine 15 mg tablet every day in the evening, and<br>- Spirivia inhaler 18 microgram (mcg) one time daily in the morning. | 01910 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| 01910 | Continued From page 40<br><br>R2's medication disposition record lacked the content to include:<br>- medication's name,<br>- strength,<br>- prescription number as applicable,<br>- quantity,<br>- to whom the medications were given,<br>- date of disposition, and<br>- names of staff and other individuals involved in the disposition.<br><br>On August 9, 2022, at approximately 12:45 p.m., registered nurse (RN)-C acknowledged R2's discharge record was lacking the required content. In addition, RN-C stated R2 did not have any medications at the time of discharge.<br><br>The licensee's Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated that prior to providing medication management services, the licensee will have a registered nurse conduct an assessment to determine what medication management services will be provided and how the services will be provided. The policy lacked verbiage to include content of disposed medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |
| 02040 SS=F | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the | 02040 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 34173 | A. BUILDING: _____ B. WING _____ | 08/12/2022 |

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|---|---|---|---|---|
| 02040 | Continued From page 41<br>following additional requirements:<br>(1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 residents).<br><br>The findings include:<br><br>Survey staff requested a facility hazard vulnerability or safety risk assessment documentation, but the licensee did not provide the requested documentation.<br><br>During interview on August 9, 2022, at 11:15 a.m., the office manager (OM)-D stated they had not conducted a hazard vulnerability assessment on and around the property.<br><br>No further information provided. | 02040 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 02040 | Continued From page 42<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02040 | | |
| 02110 SS=F | 144G.82 Subd. 3 Policies<br><br>(a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the:<br>(1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;<br>(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br>(5) staff training specific to dementia care;<br>(6) description of life enrichment programs and how activities are implemented;<br>(7) description of family support programs and efforts to keep the family engaged;<br>(8) limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br>(9) transportation coordination and assistance to and from outside medical appointments; and<br>(10) safekeeping of residents' possessions.<br>(b) The policies and procedures must be provided | 02110 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 34173 | A. BUILDING: _____ B. WING _____ | 08/12/2022 |

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|---|---|---|---|---|
| 02110 | Continued From page 43<br>to residents and the residents' legal and designated representatives at the time of move-in.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee was licensed as an Assisted Living with Dementia Care on August 1, 2021, and holds a current license effective until March 31, 2023.<br><br>The surveyor reviewed the licensee's policies on August 9, 2022, and the following required policies and procedures were not developed/implemented:<br>-Philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented;<br>-Evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>-Wandering and egress prevention that provides | 02110 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| HEALTHPOINT HWS @ 93RD | 351 93RD AVENUE NE BLAINE, MN 55434 |

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|---|---|---|---|---|
| 02110 | Continued From page 44<br><br>detailed instructions to staff in the event a resident elopes;<br>-Medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br>-Staff training specific to dementia care;<br>-Description of life enrichment programs and how activities are implemented;<br>-Description of family support programs and efforts to keep the family engaged;<br>-Limiting the use of public address and intercom systems for emergencies and evacuation drills only;<br>-Transportation coordination and assistance to and from outside medical appointments; and<br>-Safekeeping of residents' possessions.<br><br>On August 9, 2022, at approximately 12:30 p.m. registered nurse (RN)-C acknowledged the licensee had not developed the above required policies and procedures. In addition, RN-C stated the licensee was not aware of the requirement.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02110 | | |
| 02260 SS=C | 144G.90 Subd. 3 Notice of dementia training<br><br>An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon | 02260 | | |

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|---|---|---|---|---|
| 02260 | Continued From page 45<br>request.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, an accurate description of the dementia care training program with the required content with records reviewed.<br><br>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 the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>The licensee was licensed as an Assisted Living with Dementia Care on August 1, 2021, and holds a current license effective until March 31, 2023.<br><br>On August 9, 2022, at approximately 11:45 a.m., the surveyor requested a copy of the dementia training disclosure, but none was provided.<br><br>On August 9, 2022, at approximately 12:30 p.m., RN-C acknowledged the licensee did not have a dementia training disclosure.<br><br>The licensee's undated ALDC Notice of Dementia Training policy indicated licensee will make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of | 02260 | | |

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|---|---|---|---|---|
| 02260 | Continued From page 46<br>employees trained, the frequency of training, and the basic topics covered.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02260 | | |

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *08/08/22*
Time: 11:30:00
Report: 1031221107

# Food and Beverage Establishment Inspection Report



**Location:**
Healthpoint Hws @ 93rd
351 93rd Avenue Ne
Blaine, MN55434
Anoka County, 02

**Establishment Info:**
ID #: 0039061
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6122728118
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.

**2-200 Employee Health**

***2-201.11C*** ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

ESTABLISHMENT DID NOT HAVE ILLNESS LOG ON SITE. COPY OF LOG SENT WITH REPORT. KEEP ILLNESS LOG ON SITE AND UP TO DATE.

*Comply By: 08/08/22*

**3-500A Microbial Control: cooling**

***3-501.14A*** ***** Priority 1 *****

MN Rule 4626.0385A Cool cooked TCS food: 1. within 2 hours from 135 degrees F (57 degrees C) to 70 degrees F (21 degrees C); and 2. within a total of 6 hours from 135 degrees F (57 degrees C) to 41 degrees F (5 degrees C) or less.

TWO CONTAINERS OF PORK ROAST MEASURED. 46-47F IN CENTER. EMPLOYEE STATED ITEMS WERE PLACED IN REFRIGERATOR ABOUT 5:30PM SUNDAY. ***ITEMS DISCARDED*** COOL IN SHALLOW PANS WITH LIDS OFF. MONITOR TEMPERATURES.

*Comply By: 08/08/22*

**3-500B Microbial Control: hot and cold holding**

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

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

EGG SALAD AND LETTUCE FOUND IN REFRIGERATOR MEASURED 50F. ***ITEMS DISCARDED*** MONITOR TEMPERATURES.

*Comply By: 08/08/22*

**3-700 Contaminated Food: discarded**

***3-701.11A*** ***** Priority 1 *****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

EGG SALAD AND TURKEY FOUND WITH BLACK SUBSTANCE IN/ON PRODUCT. OPEN PACKAGE OF HAM FOUND WITH TAN, GELATINOUS SUBSTANCE ON MEAT. ***ALL PRODUCTS DISCARDED***

*Comply By: 08/08/22*

**3-500C Microbial Control: date marking**

***3-501.17A*** ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

ALL EGG SALAD, CHICKEN SALAD, TURKEY, AND HAM PACKAGES MISSING DATE MARKING. DATES WERE ADDED TO FOODS. BAG LETTUCE FOUND OUT OF DATE AND DISCARDED. MAKE SURE ALL ITEMS ARE DATED AND DISCARDED WITHIN 7 DAYS OF DATE WRITTEN.

*Comply By: 08/08/22*

**4-300 Equipment Numbers and Capacities**

***4-302.14*** ***** Priority 2 *****

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

ESTABLISHMENT DOES NOT HAVE SANITIER TESTING KIT ON SITE. PROVIDE AND USE TEST KIT TO CHECK SANITIZER CONCENTRATION.

*Comply By: 08/10/22*

**2-100 Supervision**

***2-102.12AMN***

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM).

*Comply By: 08/08/22*

**3-300C Protection from Contamination: equipment/utensils, consumers**

***3-304.14B***

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WIPING CLOTH FOUND WET AND RESTING IN 2-COMP SINK. STORE ALL WIPING CLOTHS AS DIRECTED ABOVE.

*Comply By: 08/09/22*

**4-600 Cleaning Equipment and Utensils**

***4-602.12***

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

INTERIOR OF MICROWAVE AND OVEN FOUND WITH FOOD DEBRIS AND DRIED FOOD SUBSTANCES ON ALL SURFACES. CLEAN AND MAINTAIN CLEAN.

*Comply By: 08/10/22*

**6-500 Physical Facility Maintenance/Operation and Pest Control**

***6-501.12A***

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

POT RACK FOUND WITH DEBRIS AND SPIDER WEBS ON POT RACK SURFACE AND SUSPENSION CHAIN. CLEAN AND MAINTAIN CLEAN.

*Comply By: 08/11/22*

**8-300 License to Operate**

***8-301.11B***

MN Rule 4626.1755B Post the license so it is conspicuous to consumers.

ESTABLISHMENT DOES NOT HAVE LICENSE ON SITE.

*Comply By: 08/08/22*

**Food and Equipment Temperatures**

Process/Item: Cold Hold/Ham
Temperature: 47 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Cold Hold/Egg Salad
Temperature: 50 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Cold Hold/Milk
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Ck Salad
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Egg Salad 2
Temperature: 43 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Cold Hold/Salad
Temperature: 50 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Cold Hold/Ck Salad 2
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Pork Roast
Temperature: 46 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

Process/Item: Cold Hold/Pork Roast
Temperature: 46 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: Yes

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 4 | 2 | 5 |

Inspection conducted by Chris F, in the presence of Carrie
.
All violations discussed with Carrie during the inspection.

NOTES:
- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods of preparation of foods the day prior. Any remaining food from meals to be removed/discarded at end of day.

- Residents have their own food/beverages in separate refrigerators that they prepare themselves.

- Staff should be washing hands every time they prepare foods in kitchen.

- Residents should be washing their hands every time they use the kitchen.

- Gloves should be used for single-purpose only; switch gloved whenever leaving kitchen to do other work.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Extra care needs to be taken when cleaning behind cabinet hardware so debris does not build up.

- Establishment does not have 3-comp sink - can use residentia dishwasher to wash and rinse, but will need to use sink basin to sanitize and air dry dishes, as discussed during inspection.

- 2-Comp sink is not to be used for handwashing; used for food prep only.

- Smaller, 1-comp sink to right of 2-comp sink designated for handwashing only.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures

- Make sure to keep same foods in refrigerator grouped together. Use FIFO (first in, first out) method discussed on site.

- When preparing food from raw, make sure to use a thermometer to check cook temperatures.

# 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 Environmental Health inspection report number 1031221107 of 08/08/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

**Inspection report reviewed with person in charge and emailed.**

Signed:_____
Carrie Vernier
Person in Charge

Signed:_____
Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031221107

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

| | | | |
|---|---|---|---|
| No. of RF/PHI Categories Out | 7 | Date | 08/08/22 |
| No. of Repeat RF/PHI Categories Out | 0 | Time In | 11:30:00 |
| Legal Authority MN Rules Chapter 4626 | | Time Out | |

| | Address | City/State | Zip Code | Telephone |
|---|---|---|---|---|
| Healthpoint Hws @ 93rd | 351 93rd Avenue Ne | Blaine, MN | 55434 | 6122728118 |

| License/Permit # | Permit Holder | Purpose of Inspection | Est Type | Risk Category |
|---|---|---|---|---|
| 0039061 | | 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 |
|---|---|---|---|---|
| | **Supervision** | | | |
| 1 | (IN) OUT | PIC knowledgeable; duties & oversight | | |
| 2 | IN (OUT) N/A | Certified food protection manager, duties | | |
| | **Employee Health** | | | |
| 3 | IN (OUT) | Mgmt/Staff;knowledge,responsibilities&reporting | | |
| 4 | (IN) OUT | Proper use of reporting, restriction & exclusion | | |
| 5 | (IN) OUT | Procedures for responding to vomiting & diarrheal events | | |
| | **Good Hygenic Practices** | | | |
| 6 | IN OUT (N/O) | Proper eating, tasting, drinking, or tobacco use | | |
| 7 | (IN) OUT N/O | No discharge from eyes, nose, & mouth | | |
| | **Preventing Contamination by Hands** | | | |
| 8 | IN OUT (N/O) | Hands clean & properly washed | | |
| 9 | (IN) OUT N/A N/O | No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed | | |
| 10 | (IN) OUT | Adequate handwashing sinks supplied/accessible | | |
| | **Approved Source** | | | |
| 11 | (IN) OUT | Food obtained from approved source | | |
| 12 | IN OUT N/A (N/O) | Food received at proper temperature | | |
| 13 | (IN) OUT | Food in good condition, safe, & unadulterated | | |
| 14 | IN OUT (N/A) N/O | Required records available; shellstock tags, parasite destruction | | |
| | **Protection from Contamination** | | | |
| 15 | (IN) OUT N/A N/O | Food separated and protected | | |
| 16 | IN (OUT) N/A | Food contact surfaces: cleaned & sanitized | | |
| 17 | IN (OUT) | Proper disposition of returned, previously served, reconditioned, & unsafe food | | |

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

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

## GOOD RETAIL PRACTICES

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

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

| | | | 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 | X | 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 | X | Physical facilities installed, maintained, & clean | | |
| 56 | | Adequate ventilation & lighting; designated areas used | | |
| 57 | | Compliance with MCIAA | | |
| 58 | X | Compliance with licensing & plan review | | |

**Food Recalls:**

**Person in Charge (Signature)** **Date:** 08/08/22

Inspector (Signature)