Electronically Delivered
February 1, 2023

Licensee
Centennial Villa Assisted Living
500 Park Street East
Annandale, MN 55302

RE: Project Number(s) SL25919015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 11, 2023, 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.

LICENSING ORDERS
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 . . ."

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

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in 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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25919	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25919015-0 On January 9, 2023, through January 11, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 25 residents, all of whom received 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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following	0 500		

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0 500	Continued From page 1 and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel	0 500		

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0 500	Continued From page 2 performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on January 9, 2022, at approximately 9:55 a.m., the evaluators requested to review the licensee's current policies and procedures. The licensee failed to ensure the following policy was in place: - ensuring that nurses and licensed health professionals have current and valid licenses to practice. On January 11, 2022, at approximately 1:45 p.m., administrative assistant (AA)-I stated they were unable to locate this policy. No further information was provided.	0 500		

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0 500	Continued From page 3 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information to include the contact information for the individuals who were responsible for handling resident grievances. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 550		

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0 550	Continued From page 4 The findings include: The licensee failed to post information including the e-mail contact information for the individuals who were responsible for handling resident grievances. During the facility tour on January 9, 2022, at 10:33 a.m., the evaluators observed the entry area, common areas, and dining areas within the facility with clinical nurse supervisor (CNS)-A, registered nurse (RN)-C, and director of housing (DH)-B, and noted the grievance procedure was posted by the main entryway. The licensee's Complaints/Grievances procedure listed the names, titles, and telephone numbers for the persons to contact with a grievance internally. However, it lacked the e-mail contact information. On December 9, 2022, at 1:40 p.m., DH-B stated the e-mail contact information was not listed as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by	0 640		

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0 640	Continued From page 5 the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to post information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. During the facility tour on January 9, 2022, at 10:33 a.m., the evaluators observed the entry area, common areas, and dining areas within the facility with clinical nurse supervisor (CNS)-A,	0 640		

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0 640	Continued From page 6 registered nurse (RN)-C, and director of housing (DH)-B, and noted there was no posting of the information and reporting number for MAARC, as required. On December 9, 2022, at 1:40 p.m., DH-B said they did not have the MAARC information posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on	0 660		

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0 660	Continued From page 7 the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including TB training on hire for one of two employees (clinical nurse supervisor/CNS-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB Risk Assessment dated November 21, 2022, indicated a low risk level. CNS-A was hired on October 10, 2022, to provide direct care and services to the licensee's residents. CNS-A's employee record lacked documented evidence of the following: - TB training on hire. On January 11, 2023, at 1:17 p.m., CNS-A stated she did not receive any TB training on hire. The licensee's Employee Tuberculosis policy dated reviewed September 2019 noted training and information regarding TB would be provided during orientation and yearly, and written documentation of compliance would be kept in the personnel file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control	0 660		

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0 660	Continued From page 8 in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated TB training was required at the time of hire for all health care workers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule.	0 680		

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0 680	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 10, 2023, at 2:47 p.m., the evaluator observed the licensee's emergency preparedness plan in the main entrance of the facility on a table in a red binder. The licensee's plan contained a flip chart of various emergency situations. The plan contained direction on making an emergency plan and listed various emergency situations (such as heat, several weather emergencies, emergency evacuations, plan activations). The licensee's plan lacked the following required content: - a communication plan that included: - names and contact information for the Office of Ombudsman for Long-Term Care (OOLTC). On January 11, 2023, at 12:49 p.m., administrative assistant (AA)-I stated that she did	0 680		

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0 680	Continued From page 10 not know if the OOLTC contact was in the plan and would check with the director of housing (DH)-B. The licensee's Plans for Natural Disaster and Emergencies policy dated July 18, [no year], indicated the plan would be updated regularly and would be coordinated with local emergency responders, and where appropriate, with management of senior housing buildings where clients [residents] live. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide portable fire extinguishers that were readily accessible to all occupants within the facility. This had the potential to directly affect all	0 790		

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0 790	Continued From page 11 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On January 11, 2023, at approximately 10:45 a.m., survey staff toured the facility with director of maintenance (DM)-H. During the facility tour, survey staff observed the required fire extinguisher was in an unlabeled cabinet and was not readily visible and accessible for use in the Cardinal Cottage, Pleasant Cottage, and Big Woods Cottage. DM-H verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 11, 2023, at approximately 10:30 a.m. with director of maintenance (DM)-H, stains from a water leak were observed in the Cardinal Cottage on the ceiling tile in the corridor near resident room 703. It was also observed that drywall tape was coming apart at the seam on the ceiling at the peak in the living room of Cardinal Cottage and Big Woods Cottage. These deficient conditions were visually verified by DM-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25919	A. BUILDING: _____ B. WING _____	01/11/2023

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0 810	Continued From page 13	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the	0 810		

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0 810	Continued From page 14 licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review and interview were conducted on January 11, 2023, at approximately 12:00 p.m. of documents provided by director of maintenance (DM)-H on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows: Record review of the available documentation indicated the plan was not maintained specifically for the licensed assisted living facility. The fire safety and evacuation plan provided during the record review and interview was maintained for the adjacent nursing home facility. Record review of the available documentation	0 810		

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0 810	Continued From page 15 indicated that the fire safety and evacuation plan did not include a floor plan showing location and number of resident rooms. Record review of the available documentation indicated that the fire safety and evacuation plan did not include fire protection procedures for employees specific to the assisted living portion of the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include fire protection procedures for residents in the event of a fire or similar emergency. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees regarding resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter. Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required.	0 810		

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0 810	Continued From page 16 All deficiencies were verified by DM-H during the interview at approximately 12:15 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (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	01470		

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01470	Continued From page 17 other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) 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 orientation to assisted living licensing requirements and regulations prior to providing services for two of three employees (clinical nurse supervisor (CNS)-A and registered nurse (RN)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01470		

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01470	Continued From page 18 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-A CNS-A was hired on October 10, 2022, to provide direct care and services to the licensee's residents. CNS-A's employee record lacked documented evidence of the following: - principles of person-centered planning/service delivery. RN-F RN-F was hired on January 1, 2023, to provide direct care and services to the licensee's residents. RN-F's employee record lacked documented evidence of the following: - overview of Assisted Living statues; - review of the provider's policies and procedures; - handling of resident complaints, reporting of complaints, and where to report; - consumer advocacy services; - review of types of Assisted Living services the employees will provide and provider's scope of license; and - principles of person-centered planning/service delivery. On January 11, 2023, at approximately 1:20 p.m., CNS-A and administrative assistant (AA)-I stated the employees had not received the above required training.	01470		

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01470	Continued From page 19 The licensee's Orientation, Competency, and Annual Training Requirements policy dated April 2022 noted training content for unlicensed personnel included an overview of the statutes, (144G), an introduction and review of all the provider's policies and procedures related to the provision of assisted living services, the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person, handling of resident complaints, reporting of complaints, and where to report complaints including information on the Office of Health Facility Complaints, consumer advocacy services, and a review of the types of Assisted Living services the employee would be providing and the provider's category of licensure. The policy did not reference the licensee's requirements for licensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620		

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01620	Continued From page 20	01620		

and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive resident reassessment within 90 calendar days from the last assessment for one of three residents (R1).

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

The findings include:

R1's record lacked a reassessment and monitoring no more than 90 days from the date of the last assessment.

R1's diagnoses included non-Hodgkin's lymphoma.

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01620	Continued From page 21 R1's Addendum A (Section IV-2) identified as the service plan and addendum to the contract, dated August 10, 2022, noted services including medication administration, assistance with toileting and mobility, and oxygen support. R1's record contained RN Comprehensive Assessments dated August 10, 2022, and November 22, 2022, (104 days after the last assessment). On January 11, 2023, at approximately 1:05 p.m., clinical nurse supervisor (CNS)-A stated the assessments were greater than 90 days apart, and added she was new and in the process of getting the assessments done timely. The licensee's Initial and Ongoing Nursing Assessment of Residents policy dated revised August 2021 noted the RN would complete an assessment no less than every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=C	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring	01650		

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01650	Continued From page 22 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for three of three residents (R1, R3, and R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1, R3, and R2's records lacked a service plan to	01650		

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01650	Continued From page 23 include the following required content: - schedule and methods of monitoring reviews or assessments of the resident. R1 R1's diagnoses included non-Hodgkin's lymphoma. R1's Assisted Living Contract dated effective August 1, 2021, noted: - a registered nurse or licensed practical nurse (LPN) under the direction of a registered nurse would review and monitor all health-related services provided to the resident within 14 days of admission and at least every 90 days thereafter, or more frequently if indicated by a nursing assessment. The contract incorrectly noted the LPN would assess the resident. R1's Addendum A (Section IV-2) identified as the service plan and addendum to the contract, dated August 10, 2022, noted services including medication administration, assistance with toileting and mobility, and oxygen support. R3 R3's diagnoses included atrial fibrillation and dementia. R3's Addendum A (Section IV-2) identified as the service plan dated June 2, 2022, noted services including medication administration, assistance with showering, and assistance with dressing. R3's Assisted Living Contract dated effective June 7, 2022, noted: - a registered nurse or licensed practical nurse under the direction of a registered nurse would review and monitor all health-related services provided to the resident within 14 days of	01650		

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01650	Continued From page 24 admission and at least every 90 days thereafter, or more frequently if indicated by a nursing assessment. The contract incorrectly noted the LPN would assess the resident. R2 R2's diagnosis included other symptoms and signs of cognitive functions and awareness. R2's Addendum A (Section IV-2) identified as the service plan dated August 9, 2022, noted services including medication administration, assistance with showering, incontinent care as needed, assist with grooming and hygiene, lab draws, incidental caregiver services, incidental nursing services, and monthly nail care. R2's Assisted Living Contract dated effective August 9, 2022, noted: - a registered nurse or licensed practical nurse under the direction of a registered nurse would review and monitor all health-related services provided to the resident within 14 days of admission and at least every 90 days thereafter, or more frequently if indicated by a nursing assessment. The contract incorrectly noted the LPN would assess the resident. On January 11, 2022, at approximately 1:05 p.m., clinical nurse supervisor (CNS)-A stated she was aware the registered nurse must complete the assessments, and stated the same format was utilized for all residents. The licensee's Contents of Service Plans policy dated July 10, 2017, noted the service plan included the schedule and methods of monitoring reviews or reassessments of the client [resident]. No further information was provided.	01650		

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01650	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (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 (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on available record review and interview, the licensee did not provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	02040		

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02040	Continued From page 26 A record review and interview were conducted January 11, 2023, at approximately 12:15 p.m. with director of maintenance (DM)-H on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around this specific property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (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: (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; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25919	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

(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
02110	Continued From page 27 how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed and provided to each resident and the residents' legal and designated representatives at the time of move-in. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2022.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25919	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

(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
02110	Continued From page 28 The licensee lacked evidence the following required policies and procedures related to the dementia care had been developed and provided to each resident and/or the resident's legal and designated representative: - 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; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - description of life enrichment programs and how activities are implemented; and - description of family support programs and efforts to keep the family engaged. On January 11, 2023, at approximately 1:40 p.m., director of housing (DH)-B stated they had not developed the above required policies, and they had not been provided to the resident and their legal representative and designated representative as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including:	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25919	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

(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
02140	Continued From page 29 (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia (clinical nurse supervisor (CNS)-A), had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2022. During the entrance conference on January 9, 2023, at 9:55 a.m., CNS-A stated she oversaw the dementia care training for staff. CNS-A's employee record indicated she had completed 8.5 hours of dementia care training	02140		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25919	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

(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
02140	Continued From page 30 since her hire date of October 10, 2022. CNS-A's record lacked evidence of demonstrated competency to be the person in charge of overseeing staff training for dementia care. On January 11, 2023, at approximately 1:20 p.m., CNS-A and administrative assistant (AA)-I stated they were aware CNS-A had not completed the competency/knowledge test and would be getting that completed now. The licensee's Assisted Living and Assisted Living with Memory Care Dementia Training policy dated February 7, 2022, noted persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia training including successfully passing a skills competency or knowledge test required by the commissioner. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral	02170		

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	25919	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

(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
02170	Continued From page 31 interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation, for three of three residents (R1, R3 and R2) who resided in the assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive	02170		

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	25919	A. BUILDING: _____ B. WING _____	01/11/2023

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CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

(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
02170	Continued From page 32 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2022. R1 R1's diagnoses included non-Hodgkin's lymphoma. R1's Addendum A (Section IV-2) identified as the service plan and addendum to the contract, dated August 10, 2022, noted services including medication administration, assistance with toileting and mobility, and oxygen support. R1's Resident Participation Review dated November 19, 2022, noted R1 voiced his own preferences and preferred independent or 1:1 activities. It also noted R1 enjoyed exercise and sports, watching television and movies, the news, and visiting. However, it lacked an evaluation of the resident's current abilities and skills. R1's record lacked an individualized activity plan based on the activity evaluation that reflected R1's activity preferences and needs, as required. R3 R3's diagnoses included atrial fibrillation and dementia. R3's Addendum A (Section IV-2) identified as the service plan dated June 2, 2022, noted services including medication administration, assistance with showering, and assistance with dressing.	02170		

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	25919	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

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02170	Continued From page 33 R3's Resident Participation Review dated November 19, 2022, noted R3 voiced his own preferences and preferred 1:1 and small or large group activities. It also noted R3 enjoyed music, reading and writing, spiritual and religious activities, watching television and movies, and being outdoors. However, it lacked an evaluation of the resident's current abilities and skills. R3's record lacked an individualized activity plan based on the activity evaluation that reflected R3's activity preferences and needs, as required. R2 R2's diagnosis included other symptoms and signs of cognitive functions and awareness. R2's Addendum A (Section IV-2) identified as the service plan dated August 9, 2022, noted services including medication administration, assistance with showering, incontinent care as needed, assist with grooming and hygiene, lab draws, incidental caregiver services, incidental nursing services, and monthly nail care. R2's Resident Participation Review dated November 11, 2022, noted R2 voiced her own preferences and preferred independent or smaller groups and in own room or day room. It also noted R2 enjoyed cards, word games, and other games. However, it lacked an evaluation of the resident's current abilities and skills. R2's record lacked an individualized activity plan based on the activity evaluation that reflected R2's activity preferences and needs, as required. On January 11, 2022, at approximately 12:49 p.m., clinical nurse supervisor (CNS)-A and administrative assistant (AA)-I stated the record lacked the above required content. In addition,	02170		

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	25919	A. BUILDING: _____ B. WING _____	01/11/2023

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CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

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02170	Continued From page 34 they said they had checked with the activity staff and no individualized activity plan had been developed for any of the licensee's residents. A policy related to the activity evaluation and plan was requested but not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with an assistive device (consumer bed rail). 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).	02310		

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CENTENNIAL VILLA ASSISTED LIVI	500 PARK STREET EAST ANNANDALE, MN 55302

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02310	Continued From page 35 The findings include: R1's diagnoses included non-Hodgkin's lymphoma. R1's Addendum A (Section IV-2) identified as the service plan and addendum to the contract, dated August 10, 2022, noted services including medication administration, assistance with toileting and mobility, and oxygen support. R1's Comprehensive Assessment dated November 22, 2022, noted R1 required partial assistance with mobility and transferring, and utilized a walker. R1's Side Rail / Transfer Bar Assessment dated November 22, 2022, noted R1 had an assist rail on the right side of the bed utilized to get in and out of bed and to help in positioning. It noted alternative options were offered and declined. In addition, the manufacturer guidelines were attached, and the device was installed per manufacturer guidelines. The risk versus benefits were discussed with resident. However, the resident's record lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for recall information. On January 10, 2023, at 2:15 p.m., clinical nurse supervisor (CNS)-A stated the CSPC had not been checked for recall, and she was not familiar with the site. The licensee's Assessing the Safety of Side Rails policy dated revised September 2019 lacked information on referring to the CPSC site for recall information.	02310		

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02310	Continued From page 36 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *01/09/23*
Time: 10:04:25
Report: 7989231003

Food and Beverage Establishment Inspection Report

Location:
Annandale Care Center
500 Park Street East
Annandale, MN55302
Wright County, 86

Establishment Info:
ID #: 0020762
Risk: High
Announced Inspection: No

License Categories:
FBLB, FBSP, FBSW

Expires on: 12/31/23

Operator:
Annandale Care Center

Phone #: 3202743737
ID #: 25887

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

No NEW orders were issued during this inspection.

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

BIG WOODS COTTAGE SERVING KITCHEN

PLEASANT COTTAGE SERVING KITCHEN

CARDINAL COTTAGE SERVING KITCHEN

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7989231003 of 01/09/23.

Certified Food Protection Manager CHELSEY LOGEAIS

Certification Number: 89945 Expires: 07/15/23

Signed: _____
Establishment Representative

Signed: Tyffani Maresh
Tyffani Maresh
Public Health Sanitarian
St Cloud
320-223-7361
Tyffani.Maresh@state.mn.us

Report #: 7989231003

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0	Date	01/09/23
No. of Repeat RF/PHI Categories Out	0	Time In	10:04:25
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Annandale Care Center	500 Park Street East	Annandale, MN	55302	3202743737

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0020762	Annandale Care Center	Full		H

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 01/09/23

Inspector (Signature) Tiffany Maruska