Electronically delivered

June 29, 2023

Licensee
Scandia Capital Partners LLC
23 Waterview Drive
Proctor, MN 55810

RE: Project Number(s) SL30617015

Dear Licensee:

On June 12, 2023, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 6, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 6, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey completed on April 6, 2023, found not corrected at the time of the June 10, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f)

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

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

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

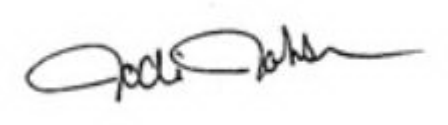
Please address your cover letter for reconsideration requests to:

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

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at jodi.johnson@state.mn.us.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30617	A. BUILDING: _____ B. WING _____	R 06/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	23 WATERVIEW DRIVE PROCTOR, MN 55810

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL SL34980015-2 On June 9, 2023, through June 12, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on April 6, 2023. At the time of the survey, there were 20 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	{0 680}		

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{0 680}	Continued From page 1 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action needed.	{0 680}		
{0 810} SS=E	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;	{0 810}		

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{0 810}	Continued From page 2 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review, the licensee failed to provide fire safety and evacuation plans with the required elements. 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) and was issued at a pattern scope (when more than a limited number	{0 810}		

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{0 810}	Continued From page 3 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). Findings include: On June 9, 2023, survey staff emailed the facility requesting documentation to support corrections for the 0810 tag that was issued on April 6, 2023. The executive director (ED)-L responded to the email on June 12, 2023, and provided emergency protocols for review. Record review of available documentation by survey staff was completed on June 21, 2023. Findings include: The licensee had not developed and maintained plans with employee actions on how to move or evacuate residents in the event of a fire or similar emergency from this facility location. The plans indicated to use the RACE and PASS acronyms and included vague instructions for employees. The plans did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee had not developed fire protection procedures necessary for residents at this facility location. The fire protection procedures for residents in the protocol were limited to putting blankets over clients and moving them outside.	{0 810}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	{01370}		

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{01370}	Continued From page 4 (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (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; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	{01370}		

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{01370}	Continued From page 5 This MN Requirement is not met as evidenced by: No further action needed.	{01370}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

April 14, 2023

Licensee
Scandia Capital Partners LLC
23 Waterview Drive
Proctor, MN 55810

RE: Initial License Number 408474
Health Facility Identification Number (HFID) 30617
Project Number(s) SL30617015

Dear Licensee:

On April 6, 2023, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the licensing evaluation completed December 8, 2022. The follow-up evaluation found the facility to be in substantial compliance. **Based on these findings, the condition(s) on the license were removed effective April 10, 2023.**

Furthermore, The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the December 8, 2022, initial evaluation.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on December 8, 2022, found not corrected at the time of the April 6, 2023, follow-up evaluation and subject to a penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - $500.00
1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a)
2040-Fire Protection And Physical Environment-144g.81 Subdivision 1 - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on April 6, 2023, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint evaluation, and as otherwise needed. 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).

IMPOSITION OF FINES:

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.

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. 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 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 Jodi Johnson directly at: 507-344-2730.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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{0 000}	Initial Comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: Project SL SL34980015-1 On April 3, 2023, through April 6, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 8, 2022. At the time of the survey, there were 16 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued and/or issued.	{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.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	{0 680}		

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{0 680}	Continued From page 1 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an emergency preparedness plan (EPP) with all required content, or practice and document testing of the plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	{0 680}		

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{0 680}	Continued From page 2 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 April 3, 2023, at 9:15 a.m., the surveyor requested the facility's emergency preparedness plan and related documentation. The licensee's Emergency Plan revised March 30, 2023, included the following: -mutual agreement of understanding with [name] to use as a temporary relocation in the event of an emergency; -names/contract information of staff, entities providing services under agreement, state and local emergency management agencies; -an evacuation plan; and -severe weather policies and procedures to include power outage, thunderstorms, and tornado watches. The licensee's EPP provided did not include the following: - a completed hazard vulnerability assessment (HVA) - policies and procedures to address man-made disasters - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and	{0 680}		

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{0 680}	Continued From page 3 waste disposal, emergency lighting, fire detection, extinguishing and alarm systems; - evacuation plan which included staff responsibilities during an evacuation; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - development of arrangements with other facilities and providers to receive residents if needed; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, other facilities, volunteers; - contact information for federal, state, tribal, local EP staff, and ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the EPP with residents and their families. On April 4, 2023, at 9:12 a.m. executive director (ED)-L stated the licensee had not fully developed an emergency plan or developed an EP manual. ED-L stated the EPP continued to be under development. The licensee's Emergency Plan policy revised March 30, 2023, indicated the licensee's assisted living director was responsible for maintaining an	{0 680}		

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{0 680}	Continued From page 4 effective and current emergency preparedness plan and implementing procedures. No further information was provided.	{0 680}		
{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	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30617	A. BUILDING: _____ B. WING _____	R 04/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	23 WATERVIEW DRIVE PROCTOR, MN 55810

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{0 810}	Continued From page 5 drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop fire safety and evacuation plans with the required elements and failed to meet the training and evacuation drill frequency requirements. 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) 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). Record review of available documentation was completed on April 6, 2023, between 10:00 a.m. and 10:30 a.m. Documents provided included the fire safety and evacuation plan, fire safety and evacuation training records, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not have specific employee actions to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have fire	{0 810}		

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{0 810}	Continued From page 6 protection procedures necessary for residents located within the plan. Record review of the available documentation indicated that employees did not receive training on the fire safety and evacuation plans upon initial hire and twice per year thereafter. The fire safety policy dated 03/20/2023 specified that employees are instructed at orientation and annually. Record review of the available documentation did not indicate that evacuation drills were conducted twice per year per shift with at least one evacuation drill every other month as required. The fire drill record from February 2023 included comments that fire drills will be completed quarterly and that the next fire drill was scheduled to be completed in June 2023. No additional evacuation drill schedules were provided. On April 6, 2023, at approximately 11:10 a.m., the executive director (ED)-L verified these deficient conditions.	{0 810}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal	{01370}		

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{01370}	Continued From page 7 hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (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; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of one unlicensed personnel (ULP)-J. 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	{01370}		

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{01370}	Continued From page 8 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on April 3, 2023, at 9:15 a.m., registered nurse (RN)-M stated new employees were required to take all Educare training (online education courses) prior to training on the floor with another ULP. RN-M stated new employees were allowed to participate in hands on care with residents while working alongside another ULP before being competency tested by the RN, but were not allowed to administer medications or treatments. ULP-J was hired on March 25, 2023, to provide direct care under the licensee's assisted living with dementia care license. ULP-J's employee file contained "Protocols for licensee's Training and Competency" document was blank and had not been completed. ULP-J's employee record lacked evidence ULP-J had received the following training and competencies: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural	{01370}		

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{01370}	Continued From page 9	{01370}		

background, and family; and
- awareness of commonly used health technology equipment and assistive devices.

The licensee's working staff schedule dated March 26, 2023, to April 8, 2023, indicated ULP-J was scheduled to train the following days:
March 27, 2023, 2:00 p.m. to 6:00 p.m.;
March 28, 2023, 6:00 p.m. to 6:00 a.m.;
March 29, 2023, 6:00 p.m. to 6:00 a.m.;
March 30, 2023, 6:00 p.m. to 6:00 a.m.;
April 3, 2023, 6:00 p.m. to 6:00 a.m.;
April 4, 2023, 6:00 p.m. to 6:00 a.m.; and
April 5, 2023, 6:00 p.m. to 6:00 a.m.

ULP-J's time sheet indicated ULP-J worked the following:
March 25, 2023, 2:00 p.m. to 6:00 p.m.;
March 26, 2023, 6:00 p.m. to 6:00 a.m.;
March 27, 2023, 2:00 p.m. to 6:00 p.m.; and
April 3, 2023, 6:00 p.m. to 6:00 a.m.

On April 3, 2023, at 3:59 p.m. ULP-N stated she assisted in training new ULP. ULP-N stated she would have the new ULP shadow for a couple of days then have the new ULP participate in resident cares like bathing, dressing, grooming, and toileting while the new ULP was training along side of her. ULP-N stated after about a week of training on the floor, the new ULP would test out with the RN and then the new ULP would be able to work independently. ULP-N stated the new ULP were not allowed to administer medications or treatments prior to testing with the RN, but were allowed to perform resident cares and assist with meals.

On April 4, 2023, at 10:05 a.m. RN-M confirmed ULP-J had been working with residents providing cares prior to completing competency evaluations

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{01370}	Continued From page 10 with the RN. RN-M stated she thought it would be good for the new employee to work alongside their preceptor to get some hands on experience with resident cares before being competency tested by the RN. The licensee's Staff Competency policy dated August, 1, 2021, indicated all residents would receive quality service delivered by staff who were educated and competent in the delivery of home care services. Unlicensed personnel may not work for the licensee until they had successfully passed the written competency test at least 80% and demonstrate competency evaluation. No further information was provided.	{01370}		
{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 record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the	{02040}		

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{02040}	Continued From page 11 physical environment on and around the property with mitigation factors. 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) 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: Record review of available documentation was completed on April 6, 2023, between 10:00 a.m. and 10:30 a.m. Documents provided included a medical hazard vulnerability analysis. This analysis identified natural, technological, hazardous materials, and human-related hazards. The licensee had not performed a hazard vulnerability assessment on and around the property for the physical environment with mitigation factors identified to protect dementia care residents from harm. On April 6, 2023, at approximately 11:10 a.m., the executive director (ED)-L verified these deficient conditions.	{02040}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

January 17, 2023

Licensee
Scandia Capital Partners LLC
23 Waterview Drive
Proctor, MN 55810

RE: Conditional License Number 408474
Health Facility Identification Number (HFID) 30617
Project Number(s) SL30617015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a licensing evaluation on December 8, 2022, for the purpose of assessing compliance with state licensing statutes. Based on the licensing evaluation results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, MDH is issuing a 90-day conditional license due to expire on **April 17, 2023**.

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 . . ."

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 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00
St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $3,000.00
St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $9,500.00. 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.

CONDITIONAL LICENSE ISSUED:
MDH will issue Scandia Capital Partners LLC a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up evaluation, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up evaluation, MDH will determine if Scandia Capital Partners LLC is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Scandia Capital Partners LLC will not admit any new residents under its conditional assisted living facility license until the MDH

removes the "no new admissions" condition. Scandia Capital Partners LLC must provide the Department:

i. A list of the names and birthdates of any individuals Scandia Capital Partners LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents by location including:
    1. Name and birthdate of each resident
    2. Physical location of each resident
    3. Current payment source for services
    4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

c. Consultant: Scandia Capital Partners LLC will contract with an RN to provide consultation concerning all resident(s) to whom Scandia Capital Partners LLC provides licensed assisted living services under the conditional license. The consultant must have access to all resident(s) receiving services from Scandia Capital Partners LLC. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Scandia Capital Partners LLC and MDH must review the RN's credentials and approve the selection. Scandia Capital Partners LLC is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Scandia Capital Partners LLC in an effort to help Scandia Capital Partners LLC align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Scandia Capital Partners LLC will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

d. Reports: The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Scandia Capital Partners LLC and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Evaluator Supervisor, State Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. Jodi Johnson can be reached at 507-344-2730 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of licensing orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. Monitoring visits: MDH may make unannounced monitoring visits to assess the progress of Scandia Capital Partners LLC to correct the violations cited during the evaluation as well as to determine the overall practice of Scandia Capital Partners LLC in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.

f. Follow-up Evaluation: At the time of the follow-up evaluation, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.

g. Corrective Action Plan: Scandia Capital Partners LLC will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:

i. A statement of the concern
ii. A description of what will happen to correct the concern
iii. A target date for when each correction will be complete
iv. Who is responsible to make sure it happens
v. Current status of correction work
vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Scandia Capital Partners LLC is in substantial compliance based on the results of the follow up evaluation. MDH will make this determination within the 90-day conditional license

period. If MDH determines Scandia Capital Partners LLC is in substantial compliance on the follow up evaluation, MDH will remove the conditions from Scandia Capital Partners LLC's assisted living facility license, and Scandia Capital Partners LLC will correct violations identified during the evaluation to come into substantial compliance. If MDH determines Scandia Capital Partners LLC is not in substantial compliance, MDH may take additional enforcement action against Scandia Capital Partners LLC, including placement of additional conditions, issuing a second conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 17 (c), the licensee may appeal an order immediately temporarily suspending a license or issuing a conditional license. The appeal must be made in writing by certified mail or personal service. If mailed, the appeal must be postmarked and sent to the commissioner within five calendar days after the license holder receives notice. If an appeal is made by personal service, it must be received by the commissioner within five calendar days after the license holder received the order. The request for hearing 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
Health.HRD.Appeals@state.mn.us

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this notice and the results of this visit with the President of your organization's Governing Body.

If you have any questions, please contact Jodi Johnson directly at: 507-344-2730.

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

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	30617	A. BUILDING: _____ B. WING _____	12/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDIA CAPITAL PARTNERS LLC	23 WATERVIEW DRIVE PROCTOR, MN 55810

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0 000	Initial Comments 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: SL#30617015 On, December 5, 2022, through December 8, 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 19 residents, all of whom received services under the provider's Assisted Living license. Immediate correction orders were identified on December 6, 2022, issued for SL#30617015, tag identifications 0495 and 2310. On December 8, 2022, the surveyor exited the facility. As of the time of exit, immediacy remained in effect for all issued immediate correction orders: 0495 and 2310.	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.	

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	30617	A. BUILDING: _____ B. WING _____	12/08/2022

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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 the residents). The findings include: On December 5, 2022, at 11:45 a.m. during the entrance conference, licensed practical nurse (LPN)-B indicated LALD-A was the LALD, but was not available due to illness. On December 6, 2022, at 10:00 a.m. the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-A held a current assisted living director license; however, LALD-A was not listed as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On December 6, 2022, at 2:00 p.m. LALD-A confirmed she was not listed as the Director of Record, and she was aware she needed to contact BELTSS to complete this. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of	0 250		

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0 250	Continued From page 3 the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 250		

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0 250	Continued From page 4 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 December 5, 2022, at approximately 11:30 a.m., licensed practical nurse (LPN)-B stated the leadership team in charge of the facility were familiar with the assisted living regulations and the licensee provided assistance with activities of daily living (ADLs), medication and treatment management services, and housekeeping. On December 6, 2022, at 2:00 p.m. the evaluator spoke with LALD-A over the phone. LALD-A stated she was ill and would not be coming in. LALD-A also confirmed she was familiar with the assisted living regulations. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17.	0 250		

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0 250	Continued From page 5 - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices.	0 250		

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0 250	Continued From page 6 - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by licensed assisted living director (LALD)-A on May 12, 2022. The licensee had an assisted living license issued on August 1, 2022, with an expiration date of April	0 250		

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0 250	Continued From page 7 30, 2023. The licensee failed to ensure the following policies and procedures were implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - 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; - infection control practices; - 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; - medication and treatment management; - delegation of tasks by registered nurses or licensed health professionals; - supervision of unlicensed personnel performing delegated tasks As a result of this survey, the following orders were issued 0495, 0510, 0650, 0660, 1370, 1380, 1440, 1540, 1610, 1620, 1730, 1830, 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 250		

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0 340	Continued From page 8	0 340		
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the immediate order tag identification 0495 and 2310 during a survey completed on December 8, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	0 340		

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0 340	Continued From page 9 or a violation that has the potential to lead to 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 December 8, 2022, Minnesota Department of Health (MDH) completed a survey resulting in 34 correction orders issued and immediate orders 0495, and 2310 issued on December 6, 2022. On December 6, 2022, at 1:45 p.m. chief manager (CM)-H was notified by MDH of immediate correction order for tags 0495 and 2310. On December 7, 2022, at 9:39 a.m. CM-H was contacted by MDH regarding the plan of correction for two immediate correction orders. The licensee failed to submit a plan of correction required to address the immediate orders. The immediacy of correction order tag identification 0495 and 2310 was not lifted by the time of survey exit. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 430 SS=B	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 10 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) with the required content for three of five residents (R2, R7, R10). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include:	0 430		

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0 430	Continued From page 11 R2 R2 diagnosis included quadriplegia, dysphagia (difficulty swallowing), and seizures. R2's started receiving services from the licensee on August 4, 2020, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2's record contained a copy of the signed UDALSA on December 7, 2022, (one day after the start of the survey). R7 R7's diagnoses included schizophrenia, diabetes and hypertension (high blood pressure). R7's started receiving services from the licensee on February 4, 2015, to assist with ADLs, medication administration, laundry, and housekeeping. R7's record lacked evidence of a UDALSA. R10 R10's diagnoses included schizophrenia. R10 started receiving services from the licensee on September 1, 2020, to assist with ADLs, medication administration, laundry, and housekeeping. R10's record lacked evidence of a UDALSA. On December 8, 2022, at 12:22 p.m. licensed practical nurse (LPN)-B indicated R2's Bill of Rights and UDALSA were sent to the designated representative for signature, after the start of the survey. LPN-B also confirmed R7 and R10 did	0 430		

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0 430	Continued From page 12 not have a copy of a signed UDALSA, Bill of rights, or the required dementia policies. LPN-B indicated that many residents were missing the required documents in their files and had a plan to complete them, but has not finished yet. The licensee's Clinical Records policy dated May 9, 2019, indicated the clinical record contains documentation of services provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=E	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights for assisted living with dementia care to three of five residents (R2, R7, R10).	0 450		

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0 450	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 diagnosis included quadriplegia, dysphagia (difficulty swallowing), and seizures. R2's started receiving services from the licensee on August 4, 2020, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2's record contained a copy of the signed Bill of Rights on December 7, 2022, (one day after the start of the survey). R7 R7's diagnoses included schizophrenia, diabetes and hypertension (high blood pressure). R7's started receiving services from the licensee on February 4, 2015, to assist with ADLs, medication administration, laundry, and housekeeping. R7's record lacked evidence a copy of the Bill of Rights was provided to the resident/representative.	0 450		

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0 450	Continued From page 14 R10 R10's diagnoses included schizophrenia. R10's started receiving services from the licensee on September 1, 2020, to assist with ADLs, medication administration, laundry, and housekeeping. R10's record lacked evidence a copy of the Bill of Rights was provided to the resident/representative. On December 8, 2022, at 12:22 p.m. licensed practical nurse (LPN)-B indicated R2's Bill of Rights and UDALSA were sent to the designated representative for signature, after the start of the survey. LPN-B also confirmed R7 and R10 did not have a copy of a signed UDALSA, Bill of rights, or the required dementia policies. LPN-B indicated that many residents were missing the required documents in their files and had a plan to complete them, but have not finished yet. The licensee's Notifications Policy date May 9, 2019, indicated the agency will obtain a written acknowledgment of the client's receipt of the home care bill of rights. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at	0 470		

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0 470	Continued From page 15 least twice a year, of the appropriateness of staffing levels in the facility; (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 (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; (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: (i) awake; (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; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the staffing plan was developed and posted as required, potentially affecting all 19 residents in the assisted living with dementia care facility, staff, and any visitors of the licensee. 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	0 470		

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0 470	Continued From page 16 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 develop and implement a staffing plan for determining it's staffing level based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract. -each resident's acuity level, as determined by the most recent assessment or individualized review. -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; and -whether the facility has a secured dementia care unit, and staff experience, training, and competency. During the facility tour on December 5, 2022, at 11:45 a.m. licensed practical nurse (LPN)-B took the surveyor to a white board just outside of the kitchen serving window. The white board had "December 4, 2022" (yesterday's date), the menu for all three meals for the day and a list of staff working for the day. The staff listed were not working that day. LPN-B was questioned regarding who was responsible for completing the board daily. LPN-B was not sure and asked the kitchen staff. The kitchen staff stated they were responsible for updating the menu, but was not sure who completed the staffing assignment. On December 6, 2022, at 2:00 p.m. the surveyor spoke to licensed assisted living director	0 470		

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0 470	Continued From page 17 (LALD)-A by phone regarding the licensee's staffing plan. LALD-A stated the licensee did have a staffing plan but due to short staffing, it was not completed and stated she would provide a copy of the staffing plan by email. The staffing plan was not provided before the exit on the survey. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota	0 480		

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0 480	Continued From page 18 Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 6, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse was available on-call 24 hours a day, seven days per week. This had the potential to affect all 21 residents and staff of the facility. This resulted in an immediate correction order on December 6, 2022, at 1:45 p.m. This practice resulted in a level three violation (a violation that did not harm a resident's health or	0 495		

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0 495	Continued From page 19 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 December 5, 2022, at approximately 11:30 a.m. during entrance conference, licensed practical nurse (LPN)-B stated she was told by the licensed assisted living director (LALD) to let the surveyor know they have hired a registered nurse (RN) for the building, but they do not know when she will start. LPN-B stated the previous RN stopped working for the licensee sometime in October. On December 6, 2022, at 11:00 a.m. LPN-B stated that they do have RN-F on-call who works for three other facilities and has agreed to "only handle emergencies." She has not completed any assessments and has never been to the facility. On December 6, 2022, at 12:30 p.m. ULP-C and ULP-E confirmed they were not aware of the RN and only spoke with LPN-B during work and after hours. On December 6, 2022, at 1:00 p.m. LPN-B introduced the surveyor to RN-D from a local Homecare agency to complete siderail assessments today. RN-D stated the owner contacted their house of representatives and someone from the House of Representatives called her (RN-D) to ask if she could come to this facility to complete siderail assessments. LPN-B confirmed RN-D was not employed by the	0 495		

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0 495	Continued From page 20 licensee, and they did not have any contracts with any home care agencies. RN-D confirmed their home care agency was told RN-F was not available today. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 495		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two unlicensed personnel (ULP-G) during personal cares for R12. 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	0 510		

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0 510	Continued From page 21 of staff are involved, or the situation has occurred only occasionally). The findings include: On December 5, 2022, at 3:00 p.m. the surveyor observed ULP-G assist R12 with changing brief. ULP-G filled a water basin with water, assembled linens, and applied gloves. After washing R12, ULP-G touched their own face with their dirty gloves. ULP-G dried R12 and then placed dirty linens on R12's bedside table and television remote. Without removing the gloves or complete hand hygiene, ULP-G assisted R4 with their television and remote. On December 6, 2022, at approximately 2:00 p.m. licensed practical nurse (LPN)-B confirmed the licensee's practice was to provide hand hygiene before and after removing gloves and providing cares. The licensee's Infection Control policy dated August 1, 2021, indicated the practice of employees will conform with OSHA regulation, current law, and currently accepted standards of practice to ensure employee and client safety. Hands are washed if contaminated with blood or body fluid, immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganism between client or the environment. Gloves are worn when touching blood, body fluids, secretions, excretions, non-intact skin, mucous membranes, or contaminated items. No further information provided.	0 510		

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0 510	Continued From page 22 TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 580		

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0 580	Continued From page 23 The findings include: On December 6, 2022, at 2:00 p.m. the surveyor spoke to licensed assisted living director (LALD)-A by phone regarding the licensee's quality management activities. LALD-A stated the licensee has quality management meetings, but did not take minutes and do not have any documentation. The licensee's Quality Improvement policy dated May 9, 2019, indicated documentation of quality improvement activities is maintained and updated as needed, but not less than annually and maintained for at least two years and will be provided to the commissioner at the time of survey, investigation or renewal as requested. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 24 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees' (unlicensed personnel (ULP)-E and ULP-G) records included the required content. 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: ULP-E ULP-E employee file lacked performance evaluations.	0 650		

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0 650	Continued From page 25 ULP-E was hired on March 16, 2021, to provide direct care under the licensee's assisted living with dementia care license. On December 6, 2022, at 8:30 a.m. the surveyor observed ULP-E administering morning medications to R3 and R4. ULP-G ULP-G employee file lacked a job description. ULP-G was hired on September 13, 2022, to provide direct care under the licensee's assisted living with dementia care license. On December 5, 2022, at 3:00 p.m. the surveyor observed ULP-G providing activities of daily living (ADLs) for R12. On December 6, 2022, at 4:00 p.m. community coordinator (CC)-C and licensed practical nurse (LPN)-B confirmed ULP-E's file did not contain a performance evaluation and ULP-G's employee file did not include a job description. The licensee's Personnel Records policy dated May 9, 2019, indicated a record for each paid employee will be maintained with the required documents including signed job descriptions and performance evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control	0 660		

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0 660	Continued From page 26 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 TB (tuberculosis) prevention and control program based on the most current guidelines issued by the centers for Disease Control and Prevention (CDC) guidelines and the Minnesota Department of Health (MDH). The licensee lacked a current, updated TB risk assessment; failed to identify who from the facility was currently in charge of the TB Plan; and failed to ensure two of two unlicensed personal (ULP-E and ULP-G) were screened and tested for active TB and retained documentation in the employees' file. 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).	0 660		

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0 660	Continued From page 27 The findings include: TB RISK ASSESSMENT and TB PLAN On December 5, 2022, at 11:30 a.m. during the entrance conference, the surveyor requested the licensee's Facility TB Risk Assessment. On December 6, 2022, at 2:00 p.m. the surveyor called assisted living director (LALD)-A on the phone to finish completing the entrance conference. LALD-A stated the registered nurse (RN) was in charge of the TB risk assessment, and that she would look on the shared drive of the computer to see if one was completed before the RN left employment. On December 6, 2022, at 3:07 p.m. LALD-A responded by email with the TB policy only. The licensee's facility TB risk assessment was not provided before the survey exit on December 8, 2022, at 1:30 p.m. TB EMPLOYEE SCREENING/TESTING for ULP-E and ULP-G ULP-E was hired on March 16, 2021, to provide direct care under the licensee's assisted living with dementia care license. On December 6, 2022, at 8:30 a.m. the surveyor observed ULP-E administer morning medications to R3 and R4. ULP-G was hired on September 13, 2022, to provide direct care under the licensee's assisted living with dementia care license. On December 5, 2022, at 3:00 p.m. the surveyor observed ULP-G provide activities of daily living (ADLs) for R12.	0 660		

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0 660	Continued From page 28 ULP-E and ULP-G's employee file lacked documented evidence of TB testing or screening. On December 6, 2022, at 3:30 p.m. licensed practical nurse (LPN)-B confirmed ULP-E and ULP-G's employee files lacked evidence a TB screen and testing was completed. The licensee's TB Screening/Prevention policy dated August 1, 2021, indicated the facility will observe the recommended precautions related to TB prevention. The policy indicated the administrator is responsible for conducting the formal risk assessment and it will be completed every other year. TB baseline screening and testing is completed upon hire for all direct care providers. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated all health care settings in Minnesota should perform an initial facility TB risk assessment. A TB infection control program should include the following: written TB infection control procedures. HCW's education should focus on basic information about your health care setting's infection control plan (i.e., how to implement your early recognition, isolation, and referral procedure), especially any sections that employees are responsible for implementing. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be	0 660		

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0 660	Continued From page 29 documented in the employee's record." 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. This MN Requirement is not met as evidenced by:	0 680		

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0 680	Continued From page 30 Based on interview and record review, the licensee failed to develop an emergency preparedness plan (EP) with all required content or practice and document testing of it's plan at least twice annually as required. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 5, 2022, at 11:30 a.m., the surveyor requested the facility's emergency preparedness plan and related documentation, which was later provided. The licensee's Emergency Preparedness Manual was a binder that consisted of a document labeled CMS State Operations Manual Appendix Z- Emergency preparedness from Leading Age Minnesota. The document consisted of definitions and notification that facilities are required to develop an emergency preparedness program that meets all of the standards specified within the requirement. No other information was included in the binder. On December 8, 2022, at 8:30 a.m. licensed practical nurse (LPN)-B indicated she had checked with leadership and was told that an Appendix Z had not been completed.	0 680		

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0 680	Continued From page 31 The licensee's Emergency Preparedness policy dated May 9, 2019, indicated [the licensee] will have an identified plan in place to assure the safety and well-being of clients and staff during period of an emergency or disaster that disrupts services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. 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	0 800		

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0 800	Continued From page 32 of the residents). The findings include: On December 6, 2022, between 10:10 a.m. and 11:10 a.m., survey staff toured the facility with the licensed practical nurse (LPN)-B and the unlicensed personnel (ULP)-C. During the facility tour, survey staff observed the following: 1. The fire shield panel in the mechanical room was beeping and the trouble signal was illuminated. The fire shield panel in the entryway was flashing trouble. The ULP-C confirmed the findings during the facility tour and stated that the panels had been displaying trouble for the past couple of months. The ULP-C explained that the fire alarms were working but they were not sure why the trouble signals were displayed. 2. Documentation of an annual inspection for the fire alarm system showing that it was in normal working order was requested by survey staff but not provided. The ULP-C contacted the company listed as the service provider, but the company responded that they no longer service the fire alarm system for this facility. 3. Combustible items were stored in front of the wall heater in the shower room. The wall heater warning label directs users to maintain 3 feet of space between combustible materials and the front of this heater. 4. Electrical panels were obstructed in two of the mechanical rooms. On December 6, 2022, at approximately 12:30 p.m., the licensed practical nurse (LPN)-B and the unlicensed personnel (ULP)-C confirmed the findings during an interview. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 33	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 observation, document review, and	0 810		

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0 810	Continued From page 34 interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 6, 2022, between 10:10 a.m. and 11:10 a.m., survey staff toured the facility with the licensed practical nurse (LPN)-B and the unlicensed personnel (ULP)-C. During the facility tour, it was observed that the location and number of resident sleeping rooms were not clearly labeled on the evacuation plans posted in the facility. On December 6, 2022, between 11:10 a.m. and 12:10 p.m., documents were reviewed by survey staff. 1. The Fire Policy dated May 9, 2019, was reviewed. The fire safety and evacuation plans had not been developed and maintained for the facility location. This policy failed to include: a. the location and number of resident rooms b. employee actions to be taken in the event of a fire or similar emergency c. fire protection procedures necessary for residents d. identification of unique or unusual resident needs for movement or evacuation 2. No records documenting employee training on	0 810		

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0 810	Continued From page 35 the facility fire safety and evacuation plans were provided. The Fire Policy dated May 9, 2019, failed to provide the required employee training frequency. The policy stated that staff training for fire safety and evacuation was completed during orientation and then annually but did not require training at least twice per year after hire. The LPN-B and ULP-C explained that the licensee had not offered training for employees on the facility fire safety and evacuation plans in the past year. 3. The licensee failed to provide annual fire safety and evacuation training for residents. Documentation was requested by survey staff but not provided. The LPN-B and ULP-C stated at approximately 12:25 p.m. during an interview that residents had not been offered training. 4. The licensee failed to perform evacuation drills. No evacuation drill records or schedules were provided. The LPN-B and ULP-C stated at approximately 12:25 p.m. during an interview that evacuation drills had not been completed this year. On December 6, 2022, at approximately 12:30 p.m., the LPN-B and ULP-C confirmed during an interview that the licensee failed to develop fire safety and evacuation plans for the facility location. They also confirmed that the training and drill frequency requirements were not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 970	Continued From page 36	0 970		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 19 residents living within the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 5, 2022, at 11:30 a.m. during the entrance conference, the evaluator requested a copy of the licensee's assisted living contract. The licensee's Assisted living with Dementia Care Contract included a clause on page 17, section 2, Indemnification, indicated the "resident will	0 970		

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0 970	Continued From page 37 indemnify and hold harmless Provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property." On December 7, 2022, at 4:00 p.m. licensed practical nurse (LPN)-B reviewed contract language, section 2 indemnification and confirmed the information listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to	01370		

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01370	Continued From page 38 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (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; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of two unlicensed personnel (ULP-G). 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-G was hired on September 13, 2022, to	01370		

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01370	Continued From page 39 provide direct care under the licensee's assisted living with dementia care license. On December 5, 2022, at 3:00 p.m. ULP-G was observed providing activities of daily living (ADLs) for R12. ULP-G's employee file contained Protocols for [licensee] training and competency document that was signed by registered nurse (RN)-F, but was not completed face to face. ULP-G's employee record lacked evidence ULP-G had received the following training and competency: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - 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; and - awareness of commonly used health technology equipment and assistive devices. On December 6, 2022, at 4:00 p.m. licensed practical nurse (LPN)-B confirmed ULP-G's file did not have any evidence that competency training was completed. LPN-B further confirmed RN-F had never been in the building and did not complete a face-to-face competency training for ULP-G.	01370		

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01370	Continued From page 40 The Staff Competency policy dated August 1, 2021, indicated the RN is responsible for assessing competency throughout the orientation process. Training and competency evaluations for all unlicensed personnel may not work for [licensee] until they have successfully passed the written competency test and demonstrated competency evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and	01380		

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01380	Continued From page 41 competency evaluations included all the required training for one of two unlicensed personnel (ULP-G). 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-G was hired on September 13, 2022, to provide direct care under the licensee's assisted living with dementia care license. On December 5, 2022, at 3:00 p.m. ULP-G was observed providing activities of daily living (ADLs) for R12. ULP-G's employee file contained Protocols for [licensee] training and competency document that was signed by registered nurse (RN)-F, but was not completed face to face. ULP-G's employee record lacked evidence ULP-G had received the following training and competency: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and	01380		

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01380	Continued From page 42 - range of motioning and positioning; On December 6, 2022, at 4:00 p.m. licensed practical nurse (LPN)-B confirmed ULP-G's file did not have any evidence that competency training was completed. LPN-B further confirmed that RN-F had never been in the building, and had not completed a face-to-face competency training for ULP-G. The Staff Competency policy dated August 1, 2021, indicated the registered nurse is responsible for assessing competency throughout the orientation process. Training and competency evaluations for all unlicensed personnel may not work for [licensee] until they have successfully passed the written competency test and demonstrated competency evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional	01440		

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01440	Continued From page 43 and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of one of two unlicensed personnel (ULP-G) performing delegated tasks was completed by the registered nurse (RN). 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-G was hired on September 13, 2022, to provide direct care under the licensee's assisted living with dementia care license. On December 5, 2022, at 3:00 p.m. ULP-G was observed providing activities of daily living (ADLs) for R12. ULP-G's employee record lacked evidence of	01440		

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01440	Continued From page 44 direct supervision of ULP performing delegated tasks had been completed within 30 days of first performing the delegated tasks by a RN. On December 6, 2022, at 4:00 p.m. licensed practical nurse (LPN)-B confirmed ULP-G's file did not have any evidence of direct supervision of ULP-G performing a delegated task by a RN. The Staff Competency policy dated May 9, 2019, indicated direct supervision of unlicensed staff performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living facility and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, 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.	01540		

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01540	Continued From page 45 Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-E) completed the required amount of dementia care training in the required time frame. 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: ULP-E was hired on March 16, 2021, to provide direct care under the licensee's assisted living with dementia care license. On December 6, 2022, at 8:30 a.m. the surveyor observed ULP-E administer morning medications to R3 and R4. ULP-E's employee file contained Educare training (an electronic training software) that contained a total of 4.75 hours of dementia training from January 13, 2022, through November 9, 2022. On December 7, 2022, at 10:48 a.m. interview with community coordinator (CC)-C and ULP-E. CC-C confirmed ULP-E's training records lacked	01540		

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01540	Continued From page 46 evidence of eight hours of the required dementia training. ULP-E confirmed the only dementia training received was through Educare. The licensee's Dementia Education policy dated August 1, 2021, indicated all staff providing assisted living services to residents will be knowledgeable in how to provide safe, effective services related to dementia. The policy indicated direct care employees must have completed at least four (4) hours of initial education within 160 working hours of employee's start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.	01610		

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01610	Continued From page 47 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for one of three residents (R3) 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 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 diagnosis included diabetes and chronic kidney disease. R3's started receiving services from the licensee on March 10, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R3's record indicated the initial assessment was completed on March 11, 2022. (One day after the initiation of services). On December 8, 2022, at 9:00 a.m. licensed practical nurse (LPN)-B confirmed R3's initial assessment was completed one day after the admission date. The licensee's Assessment-Comprehensive Services policy dated August 1, 2021, indicated an initial assessment must be completed within	01610		

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01610	Continued From page 48 five days of the initiation of services. If the assessment is not completed on initiation of services, a temporary plan and agreement with the client may be established until the assessment is completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for 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.	01620		

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01620	Continued From page 49 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment on day 14 and day 90 for two of three residents (R2, R4) 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 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: R2 R2 diagnosis included quadriplegia, dysphagia (difficulty swallowing), and seizures. R2's started receiving services from the licensee on August 4, 2020, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2's record lacked evidence of any RN assessments had been completed since June 13, 2022. R4 R4 diagnosis included mild cognitive impairment. R4's started receiving services from the licensee on October 12, 2022, to assist with ADLs,	01620		

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01620	Continued From page 50 medication administration, laundry, and housekeeping. On December 8, 2022, at 9:00 a.m. licensed practical nurse (LPN)-B confirmed R2's file lacked evidence of any ongoing assessments had been completed since June 13, 2022, and R4's file contained an initial assessment, but lacked evidence of any further assessments. The licensee's Assessment-Comprehensive Services policy dated August 1, 2021, indicated the RN will provide a reassessment visit to update and evaluation of the client and services no more than 14 days after initiation of services and ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client, but cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=B	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 assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	01650		

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01650	Continued From page 51 (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 observation, interview, and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R2, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client/resident and does not affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: R2 R2 diagnosis included quadriplegia, dysphagia (difficulty swallowing), and seizures.	01650		

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01650	Continued From page 52 R2's started receiving services from the licensee on August 4, 2020, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2's service plan lacked the following required content: -the methods of monitoring staff providing services; and -the fees for services and the frequency of each service, according to the client's current review or assessment and client preferences. R3 R3 diagnosis included diabetes and chronic kidney disease. R3's started receiving services from the licensee on March 10, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R3's service plan lacked the following required content: -the methods of monitoring staff providing services; and -the fees for services and the frequency of each service, according to the client's current review or assessment and client preferences. R4 R4 diagnosis included mild cognitive impairment. R4's started receiving services from the licensee on October 12, 2022, to assist with ADLs, medication administration, laundry, and housekeeping.	01650		

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01650	Continued From page 53 R4's service plan lacked the following required content: -the methods of monitoring staff providing services; and -the fees for services and the frequency of each service, according to the client's current review or assessment and client preferences. On December 8, 2022, at 9:00 a.m. licensed practical nurse (LPN)-B confirmed R2, R3, and R4's service lacked evidence of the above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications;	01730		

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01730	Continued From page 54 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management plan for three of three residents (R2, R3, R4) to include all required content. 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 the potential to	01730		

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01730	Continued From page 55 affect a large portion or all of the residents). The findings include: During the entrance conference on December 5, 2022, at 11:30 a.m., licensed practical nurse (LPN)-B stated the licensee provided medication management services to residents at the facility. R2 R2 diagnosis included quadriplegia, dysphagia (difficulty swallowing), and seizures. R2's started receiving services from the licensee on August 4, 2020, to assist with medication management services including medication set-up and medication administration. R2's December 2022, medication administration record (MAR) included Ibuprofen (for pain), Keppra (used for seizures), Methylphenidate (used for seizures), and multi-vitamin, R2's medication management record did not include the following: - procedures for staff notifying a registered nurse/RN or appropriate licensed health professional when a problem arises with medication management services. R3 R3's diagnosis included diabetes and chronic kidney disease. R3's started receiving services from the licensee on March 10, 2022, to assist with medication management services including medication set-up and medication administration.	01730		

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01730	Continued From page 56 R3's December 2022, MAR included chewable antacid, Metformin (for diabetes), Allopurinol (for gout), Aspirin, Atorvastatin (for high cholesterol) and Basaglar Kwikpen (for diabetes). R3's medication management record did not include the following: - procedures for staff notifying a registered nurse/RN or appropriate licensed health professional when a problem arises with medication management services. R4 R4 diagnosis included mild cognitive impairment. R4's started receiving services from the licensee on October 12, 2022, to assist with medication management services including medication set-up and medication administration. R4's December 2022, MAR included Atorvastatin (lowers cholesterol), Synthroid (thyroid agent), Lisinopril (high blood pressure), Sertraline (treats anxiety) R4's medication management record did not include the following: - procedures for staff notifying a registered nurse/RN or appropriate licensed health professional when a problem arises with medication management services. On December 6, 2022, at 2:35 p.m. licensed practical nurse (LPN)-B confirmed medication records did not include information for when staff should notify a nurse. The licensee's Assessment for Medication Management Program policy dated February 7, 2019, indicated the clinician will document an	01730		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 57 individualized medication management plan, including procedures for notifying the registered nurse or licensed health profession regarding problems arising with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (R2). 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: R2 diagnosis included quadriplegia, dysphagia	01830		

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	30617	A. BUILDING: _____ B. WING _____	12/08/2022

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01830	Continued From page 58 (difficulty swallowing), and seizures. R2's started receiving services from the licensee on August 4, 2020, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2's December 2022, medication administration record (MAR) included the following: -sennokot (laxative), effective date November 24, 2021; -ibuprofen (for pain), effective date July 7, 2021; -Hiprex (antibiotic), effective July 12, 2021; -omeprazole (acid reflux), effective August 30, 2021; -pravastatin (cholesterol), effective April 30, 2021; -Effexor (antidepressant), effective August 16, 2021; -Visine (dry eyes), effective April 30, 2021; -Immodium (anti-diarrheal), effective July 29, 2020; -barrier cream, effective March 4, 2021; -aspercreme (topical pain reliever), effective August 4, 2020; -baclofen (muscle relaxant), effective April 30, 2021; -Bisacodyl (laxative), effective October 26, 2020; -miralax powder (laxative), effective April 30, 2021; -clonodine (antihypertensive), effective August 30, 2021; -nasal spray (nasal congestion), effective August 24, 2020; -lidocaine (topical pain reliever), effective April 30, 2021; -lorazepam (antianxiety), effective August 6, 2020; and -triamcinolone/clotrimazole cream (for rash), effective September 30, 2021	01830		

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01830	Continued From page 59 R2's record included an email dated December 7, 2022, (two days after the start of the survey) to the provider requesting an annual review of medications be completed. On December 7, 2022, at 1:30 p.m. licensed practical nurse (LPN)-B confirmed R2's record did not have a completed annual medication review and notification was sent to the physician December 7, 2022, at 11:30 a.m. (after the start of the survey). The licensee's Physicians' Order policy dated August 1, 2021, indicated medication and treatment orders will be renewed at least every year or when changes occur. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
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	02040		

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02040	Continued From page 60 by: Based on document review and interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that had been completed on and around the property. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 6, 2022, between 11:10 a.m. and 12:10 p.m., documents were reviewed by survey staff. A hazard vulnerability or safety risk assessment for the property was requested by survey staff but not provided. On December 6, 2022, at approximately 12:30 p.m., the licensed practical nurse (LPN)-B and the unlicensed personnel (ULP)-C confirmed during an interview that the licensee had not provided a hazard vulnerability or safety risk assessment that had been completed on and around the property. No further information was provided. 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	02110		

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02110	Continued From page 61 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 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	02110		

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02110	Continued From page 62 with dementia care were developed or implemented, and provided to each resident and/or the residents legal and designated representative at the time of move-in. This had the potential to affect all dementia care 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 lacked evidence the following required policies and procedures related to dementia care had been developed or provided to residents, their legal representatives, and designated representatives at time of move in to include the following: 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	02110		

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02110	Continued From page 63 medications. 6. description of life enrichment programs and 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. On December 8, 2022, at 8:30 a.m. licensed practical nurse (LPN)-B indicated that she had checked with leadership, and was told they did not have the required dementia policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
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 interventions. (c) An individualized activity plan must be developed for each resident based on their	02170		

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02170	Continued From page 64 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 with required content based on the evaluation, for three of three residents (R3, R4, R5) who received services under an assisted living with dementia care license. 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	02170		

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02170	Continued From page 65 failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R2 R2 diagnosis included quadriplegia, dysphagia (difficulty swallowing), major depressive disorder, and seizures. R2's started receiving services from the licensee on August 4, 2020, to assist with medication management services including medication set-up and medication administration. R2's 90-day assessment dated June 16, 2022, indicated R2 was oriented to person only and was sad/depressed due to a major depressive disorder. The assessment did not include the resident's interests. R2's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R2's record lacked the development of an individualized activity plan. R3 R3's diagnosis included diabetes and chronic kidney disease.	02170		

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02170	Continued From page 66 R3 started receiving services from the licensee on March 10, 2022, to assist with medication management services to include medication set-up and medication administration. R3's 90-day assessment dated June 28, 2022, indicated R3 was oriented to person, place, and time. The assessment did not include the resident's interests. R3's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R3's record lacked the development of an individualized activity plan. R4 R4 diagnosis included mild cognitive impairment. R4 started receiving services from the licensee on October 12, 2022, to assist with medication management services to include medication set-up and medication administration. R4's initial assessment dated October 12, 2022, indicated R4 was oriented to person, place, and time, and that the resident experienced forgetfulness and anxiety with impaired decision	02170		

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02170	Continued From page 67 making. The assessment did not include the resident's interests. R4's record lacked evidence the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - past and current interests - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R4's record lacked the development of an individualized activity plan. On December 8, 2022, at 10:20 a.m. licensed practical nurse (LPN)-B indicated the activities assessment had not been completed for any of the residents, and that they had an activities staff person a few months ago, but they only stayed for a month. There were no regular activities done, and they were in the process of trying to hire for that position. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=I	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	02310		

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02310	Continued From page 68 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 care and services were provided according to acceptable health care and medical or nursing standards for three of three residents (R5, R6, R7) with bedrails. This resulted in an immediate correction order on December 6, 2022, at approximately 9:45 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R5 R5's diagnoses schizophrenia. R5's Service Plan dated August 30, 2022, included daily medication administration and activities of daily living (ADL). On December 6, 2022, at 9:30 a.m. the surveyor along with licensed practical nurse (LPN)-B, observed one right sided halo siderail in the up position near the head of R5's bed. The siderail was attached to the bed frame. R5's siderail assessment dated December 6,	02310		

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02310	Continued From page 69 2022 (today), page 1 of the assessment was blank, page 2 indicated the family had responded to risk versus benefit and gave a verbal acknowledgment. There was no evidence the assessment had been completed. R6 R6's diagnoses included hypertension. R6's Service Plan dated August 30, 2022, included daily medication administration and assistance with ADLs. On December 6, 2022, at 9:30 a.m. the surveyor along with LPN-B, observed bilateral siderails near the head of R6's bed in the up position. The siderails were attached to the bed frame. R6's siderail assessment dated November 30, 2022, lacked evidence the assessment portion or the measurements were completed. Page 1 was left blank, and page 2 indicated the Power of attorney (POA) was aware of the risk versus benefit. R7 R7's diagnosis included schizophrenia. R7's service plan dated August 25, 2022, included daily medication administration and ADLs. On December 6, 2022, at 9:30 a.m. the surveyor along with LPN-B, observed bilateral siderails near the head of R7's bed in the up position. The siderails were attached to the bed frame. R7's side rail assessment dated March 7, 2022, did not contain evidence measurements were	02310		

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02310	Continued From page 70 completed. On December 6, 2022, at 9:30 a.m. LPN-B confirmed there was a total of seven residents with siderails, and was aware that a registered nurse was required to complete the bedrail assessment but was unaware that measurements were needed. LPN-B confirmed R5 and R6's assessments had not been completed, and R7's siderail assessment lacked exact measurements. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's Siderail Use policy dated May 9, 2019, indicated that before implementing side rails for a client, the RN will conduct a side rail assessment and the RN would re-evaluate every 90 days. No further information was provided.	02310		

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02310	Continued From page 71 TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *12/06/22*
Time: 10:00:00
Report: 1006221172

Food and Beverage Establishment Inspection Report

Location:
Scandia Capital Partners Llc
23 Waterview Drive
Proctor, MN55810
St. Louis County, 69

Establishment Info:
ID #: 0037817
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 2187400404
ID #:

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

The following orders were issued during this inspection.

3-800 Highly Susceptible Populations

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

4626.0447B(2)- STAFF ARE USING REGULAR SHELL EGGS TO MAKE POOLED SCRAMBLED EGGS/EGG DISHES FOR BREAKFAST. PROVIDE PASTEURIZED EGGS FOR THESE TYPES OF DISHES. DISCUSSED WHEN TO USE PASTEURIZED EGGS AND PROVIDED FACT SHEET. SEE COMMENTS.

Comply By: 12/06/22

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.

THE DISH MACHINE REQUIRES CHLORINE TEST STRIPS AND THE SANITIZER DISPENSER REQUIRES QUAT AMMONIA TEST STRIPS, NEITHER OF WHICH COULD BE LOCATED BY STAFF. PROVIDE BOTH TEST STRIPS TO ENSURE PROPER SANITIZING LEVELS ARE BEING MET.

Comply By: 01/01/23

4-500 Equipment Maintenance and Operation

4-501.116 ** Priority 2 **

MN Rule 4626.0815 Use the sanitizer test kit or other device to accurately measure the concentration of the sanitizing solution.

ONCE TEST STRIPS ARE ACQUIRED, TEST THE DISH MACHINE AND SANITIZERS DAILY TO

ENSURE PROPER LEVELS ARE BEING MET (50-100 PPM FOR CHLORINE AND 200-400 PPM FOR QUAT AMMONIA).

Comply By: 01/01/23

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

MULTIPLE BOXES OF FOOD WERE STORED ON THE FLOOR IN THE WALK-IN FREEZER. DISCUSSED TRYING TO ORGANIZE DIFFERENTLY TO CREATE SOME MORE STORAGE IN THE WALK-IN. STORE FOODS 6 INCHES ABOVE THE FLOOR.

Comply By: 12/07/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

THE HAND WASHING SINK USED BY STAFF IN THE DINING AREA DIDN'T HAVE A HAND WASHING SIGN. DISCUSSED PUTTING A HAND WASHING SIGN AT THIS SINK.

Comply By: 12/07/22

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Food and Equipment Temperatures

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

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: CHICKEN NOODLE SOUP
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: HAMBURGER SOUP
Violation Issued: No

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

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

COMMENTS:

INSPECTION ACCOMPANIED BY PAM SCHULTZ.

OBSERVED GOOD HAND WASHING AND GLOVE USE THROUGHOUT INSPECTION.

THE OVEN TEMPERATURE ISN'T ACCURATE BASED ON WHAT THE KNOBS ARE SET AT. STAFF CRANKED THE OVEN TO THE MAX 400 DEGREES F AND INTERNAL TEMP ONLY GOT TO AROUND 360. DISCUSSED WITH STAFF KEEPING THIS IN MIND WHEN FOLLOWING RECIPES THAT FOODS MAY TAKE LONGER TO COOK PROPERLY.

EGGS:
4626.0447 FOOD SERVED TO A HIGHLY SUSCEPTIBLE POPULATION. 3-801.11

B. Pasteurized eggs or egg products must be substituted for raw eggs in the preparation of:

(1) foods such as Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages;P1 and

(2) except as specified in item F, recipes in which more than 1 egg is broken and the eggs are combined.P1

F. Item B, subitem (2), does not apply if:

(1) the raw eggs are combined immediately before cooking for one consumer's serving at a single meal, cooked as specified in part 4626.0340, item A, subitem(1), and served immediately, such as an omelet, souffle, or scrambled eggs;

(2) the raw eggs are combined as an ingredient immediately before baking and the eggs are thoroughly cooked to a ready-to-eat form, such as a cake, muffin, or bread; or

(3) the preparation of the food is conducted under a HACCP plan that:
(a) identifies the food to be prepared;
(b) prohibits contacting ready-to-eat food with bare hands;
(c) includes specifications and practices that ensure:
i. Salmonella Enteritidis growth is controlled before and after cooking; and
ii. Salmonella Enteritidis is destroyed by cooking the eggs according to the temperature and time specified in part 4626.0340, item A, subitem (2);
(d) contains the information in part 4626.1735, item D, including procedures that:
i. control cross-contamination of ready-to-eat food with raw eggs; and
ii. delineate cleaning and sanitization procedures for food-contact surfaces; and
(e) describes the training program that ensures that the food employee responsible for the preparation of the food understands the procedures to be used.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY

EMPLOYEES ARE DIAGNOSED WITH HEPATITIS A., SHIGA TOXIN-PRODUCING E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS OR IF THERE ARE ANY FOODBORNE ILLNESS COMPLAINTS.

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 1006221172 of 12/06/22.

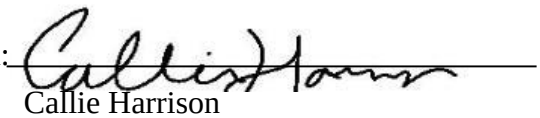
Certified Food Protection Manager: Pamela J. Schultz

Certification Number: FM112719 Expires: 08/23/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Pam Schultz
Head cook

Signed: 

Callie Harrison

218-302-6173
callie.harrison@state.mn.us

Report #: 1006221172

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	2	Date	12/06/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Scandia Capital Partners Llc	23 Waterview Drive	Proctor, MN	55810	2187400404

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037817		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	X	Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Food Recalls:

Person in Charge (Signature) **Date:** 12/08/22

Inspector (Signature) Callie Hanson