



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 20, 2025

Licensee
Whittier Place
2405 1st Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL30820015

Dear Licensee:

On January 8, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 22, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 30, 2024

Licensee
Whittier Place
2405 1st Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL30820015

Dear Licensee:

On August 19, 2024, 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 May 22, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the May 22, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on May 22, 2024, found not corrected at the time of the August 19, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on August 19, 2024 (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.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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,

A handwritten signature in black ink, appearing to read "Tim Hanna", with a long horizontal flourish extending to the right.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/19/2024
NAME OF PROVIDER OR SUPPLIER WHITTIER PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2405 1ST AVENUE SOUTH MINNEAPOLIS, MN 55404		
(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: SL30820015-1 On August 19, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on May 22, 2024. At the time of the survey, there were 65 residents; 65 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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 SUBDIVISION 1-3.		
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	{0 460}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 460}	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: No further action needed.	{0 460}			
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	{0 660}			

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{0 660}	Continued From page 2 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: No further action needed.	{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 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	{0 680}			

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{0 680}	Continued From page 3 by: No further action needed.	{0 680}			
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide physical elements that did not constitute a distinct hazard to life by not providing properly sized egress windows in all resident sleeping rooms. This deficient condition had the ability to affect all staff and residents. 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).	{0 820}			

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{0 820}	Continued From page 4 The findings include: During the phone interview on August 19, 2024, at 10:30 a.m., the president (P-G) stated that the non-compliant egress windows, identified in the original survey conducted on May 21, 2024, were not replaced. The president verified that these deficiencies remained at the time of the survey. P-G stated that the facility submitted the window replacement applications and drawings to the City of Minneapolis, and it has been in the permitting process. P-G also noted the facility has been waiting for the Heritage Preservation Application to go before the City of Minneapolis. On August 19, 2024, at 11:00 a.m., survey staff toured the facility with the housing director (HD)-A. During the facility tour, survey staff observed the following items: 2401 1st Ave. S. It was observed that occupied resident bedroom #B1 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 17.5 inches in height and 35 inches in width, with a total openable area of 612.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedrooms #18, #19, and #21 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #18 - 20 inches in height and 27 inches in width, with a total openable area of 540	{0 820}			

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{0 820}	Continued From page 5 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #19 - 18.5 inches in height and 35 inches in width, with a total openable area of 647.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. - Bedroom #21- 20 inches in height and 25 inches in width, with a total openable area of 500 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that occupied resident bedrooms #25, #26, #28, #29, and #30 on the second floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #25 - 23 inches in height and 27 inches in width, with a total openable area of 621 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #26 - 22 inches in height and 27 inches in width, with a total openable area of 594 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #28 - 21 inches in height and 29 inches in width, with a total openable area of 609 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #29- 16.5 inches in height and 25 inches in width, with a total openable area of 412.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. - Bedroom #30- 23 inches in height and 26 inches in width, with a total openable area of 598 square inches. The windows did not meet the	{0 820}			

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{0 820}	Continued From page 6 minimum requirements for total openable area. It was observed that occupied resident bedrooms #31 and #32 on the third floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows measured 39 inches in height and 17 inches in width, with a total openable area of 663 square inches. The windows did not meet the minimum requirements for opening width. 2405 1st Ave. S. It was observed that occupied resident bedrooms #5, #6, #8, and #12 on the second floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #5 - 21 inches in height and 25 inches in width, with a total openable area of 525 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #6 - 20 inches in height and 29.5 inches in width, with a total openable area of 590 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #8- 22.5 inches in height and 27 inches in width, with a total openable area of 607.5 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #12- 20.5 inches in height and 27 inches in width, with a total openable area of 553.5 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom #13 on the third floor did not have windows that	{0 820}			

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{0 820}	Continued From page 7 met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 37 inches in height and 19 inches in width, with a total openable area of 703 square inches. The windows did not meet the minimum requirements for opening width. It was observed that unoccupied resident bedroom #9 on the second floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as the below. The clear openable area of the opened windows measured 21.5 inches in height and 27 inches in width, with a total openable area of 580.5 square inches. The windows did not meet the minimum requirements for opening width. It was observed that unoccupied resident bedroom #14 on the third floor did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 37 inches in height and 19 inches in width, with a total openable area of 703 square inches. The windows did not meet the minimum requirements for opening width. 109 E. 24th Street It was observed that occupied resident bedroom #B1 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16 inches in height and 35 inches in width, with a total openable area of 560 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area.	{0 820}			

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{0 820}	Continued From page 8 It was observed that occupied resident bedrooms #33, #35, #36, #37, and #38 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #33 - 18 inches in height and 25 inches in width, with a total openable area of 450 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. - Bedroom #35 - 21 inches in height and 27 inches in width, with a total openable area of 567 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #36- 20.5 inches in height and 27.5 inches in width, with a total openable area of 563.75 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #37- 20.5 inches in height and 31 inches in width, with a total openable area of 635.5 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #38- 21 inches in height and 29 inches in width, with a total openable area of 609 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that occupied resident bedrooms #39, #40, #42, #43, and #45 on the second floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #39 - 20 inches in height and 25 inches in width, with a total openable area of 500 square inches. The windows did not meet the	{0 820}			

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{0 820}	Continued From page 9 minimum requirements for total openable area. - Bedroom #40 - 24 inches in height and 26 inches in width, with a total openable area of 624 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #42 - 21 inches in height and 27 inches in width, with a total openable area of 569 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #43 - 20 inches in height and 27 inches in width, with a total openable area of 540 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #45- 20 inches in height and 29 inches in width, with a total openable area of 580 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom #46 and #47 on the third floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows measured 32 inches in height and 19 inches in width, with a total openable area of 608 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. 2409 1st Ave. S. It was observed that occupied bedroom A in the resident #2 on the first floor did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 23.5 inches in height and 27 inches in width, with a total openable area of 634.5 square inches. The windows did not meet the minimum requirements for total openable area.	{0 820}			

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{0 820}	Continued From page 10 It was observed that occupied bedroom A in the resident #10 on the third floor did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16 inches in height and 27 inches in width, with a total openable area of 432 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HD-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. During the facility tour, HD-A visually verified these deficient findings at the time of discovery. During the phone interview on August 19, 2024, at 10:30 a.m., the president (P)-G stated that the resident sleeping rooms listed above did not have windows that met the minimum size requirements for egress escape and confirmed the findings.	{0 820}			
{0 970} SS=C	144G.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	{0 970}			

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{0 970}	Continued From page 11 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: No further action needed.	{0 970}			
{01370} SS=F	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 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	{01370}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/19/2024
NAME OF PROVIDER OR SUPPLIER WHITTIER PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2405 1ST AVENUE SOUTH MINNEAPOLIS, MN 55404			
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{01370}	Continued From page 12 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: No further action needed.	{01370}			
{01380} SS=F	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: No further action needed.	{01380}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/19/2024
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{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action needed.	{01440}			
{01500} SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:	{01500}			

Minnesota Department of Health

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{01500}	Continued From page 14 (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated	{01500}			

Minnesota Department of Health

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{01500}	Continued From page 15 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01500}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and	{01790}			

Minnesota Department of Health

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{01790}	Continued From page 16 (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: No further action needed.	{01790}			

Minnesota Department of Health

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{01890} SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action needed.	{01890}			
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: No further action needed.	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 18	{01910}			
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action needed.	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 08/19/2024
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{01970}	Continued From page 19	{01970}			
{01970} SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: No further action needed.	{01970}			



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

August 21, 2024

Licensee
Whittier Place
2405 1st Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL30820015

Dear Licensee:

Please note: This letter amends the previous letter dated July 3, 2024, specifically, to rescind the fine imposed on tag 0820. Tag 0820 remains issued with no change to the findings. You no longer have rights to reconsideration or hearing, and you do not need to act on the informal conference request as this has been fulfilled.

The Minnesota Department of Health (MDH) completed a survey on May 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s)

identified in the correction order.

- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with WHITTIER PLACE. Please contact Jess Schoenecker at 651-201-3789 **on or before July 12, 2024** to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

July 3, 2024

Licensee
Whittier Place
2405 1st Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL30820015

Dear Licensee:

Please note: This letter amends the previous letter dated July 1, 2024. Specifically, to add Informal Conference language requiring provider response on or before July 12, 2024. No other changes have been made.

The Minnesota Department of Health (MDH) completed a survey on May 22, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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 may be 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.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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 survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may

Whittier Place

July 3, 2024

Page 3

request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with WHITTIER PLACE. Please contact Jess Schoenecker at 651-201-3789 **on or before July 12, 2024** to schedule the conference call.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

AH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 1, 2024

Licensee
Whittier Place
2405 1st Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL30820015

Dear Licensee:

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IMPOSITION OF FINES

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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.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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 survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER WHITTIER PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 2405 1ST AVENUE SOUTH MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30820015-0 On May 20, 2024, through May 22, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 65 residents all of whom received services under the provider's Assisted Living license. An immediate correction order was identified on May 22, 2024, issued for SL30820015-0, tag identification 0820. On May 22, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of I.	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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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 SUBDIVISION 1-3.		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements	0 460			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2024
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0 460	Continued From page 1 (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had a potential to affect all licensee's residents. 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 the residents). The findings include:	0 460			

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0 460	Continued From page 2 On May 20, 2024, at 10:30 a.m., during the entrance conference, licensed assisted living director (LALD)-C stated licensee did not have a system in place for residents to call for help 24 hours a day, seven days a week in the resident rooms. Residents can use the red phones (one way intercom system) located in each building to summon help if needed or use their personal cell phones. On May 20, 2024, at 1118am, during the a facility tour, the surveyor did not observe a call system in the resident rooms. The surveyor observed red phones in the common hallways outside of the resident rooms. On May 20, 2024, at 12:34 p.m., surveyor interviewed a resident looking for a staff member. The resident stated to the surveyor they did not know how to use the red phone (intercom system) and was not able to walk to another building located on the licensee's campus. The resident then said "forget it" and walked away from surveyor. On May 23, 2024, at 12:06 p.m., during the exit conference, president (P)-G stated residents can page overhead, and all residents have our contact numbers. P-G also stated licensee did not know the call system must be in the rooms. P-G stated, "I don't see that the statues specifically states the call system must be in the rooms". P-G acknowledged all residents do not have a cell phone and may not be able to get to the intercom system located outside of the resident room during times of acute illness. No further information was provided.	0 460			

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0 460	Continued From page 3	0 460			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included TB history and symptom screen for three of three employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 660			

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0 660	Continued From page 4 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's TB facility risk assessment dated June 1, 2023, indicated the licensee was at low risk for TB. ULP-D ULP-D was hired on March 30, 2023, to provide direct care services to residents. ULP-D's record included a QuantiFERON-TB gold plus test dated March 20, 2024, with a negative result. ULP-D's record lacked TB history and symptom screen completed at hire. ULP-E ULP-E was hired on December 14, 2020, under the former comprehensive license and started to provide assisted living services to residents on August 1, 2021. ULP-E's record included a QuantiFERON-TB gold plus test dated December 11, 2020, with a negative result. ULP-E's record lacked TB history and symptom screen completed at hire. ULP-F ULP-F was hired on April 11, 2022. ULP-F's record included a QuantiFERON-TB gold plus test dated March 25, 2022, with a negative result.	0 660			

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0 660	Continued From page 5 ULP-F's record lacked TB history and symptom screen completed at hire. On May 22, 2024, at 2:40 p.m., licensed assisted living director (LALD)-C stated the licensee had a provider who completed their TB screening and testing for all their new staff, but since they changed to the current provider, the licensee did not realize the provider was not completing TB history and symptom screening until now. The Minnesota Department of Health's, Assisted Living Resources & Frequently Asked Questions (FAQs) dated April 3, 2024, indicated baseline TB screening includes: - assessing for current symptoms of active TB disease; - assessing TB history; and - testing for the presence of Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. The Minnesota Department of Health's, "Regulations for Tuberculosis Control in Minnesota Health Care Setting, A guide for implementing tuberculosis (TB) infection control regulations in your facility" dated June 30, 2023, indicated the following: Before the health care worker (HCW) has direct patient contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease	0 660			

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0 660	Continued From page 6 since the chest X-ray was done, and 4. Medical evaluation to rule out a diagnosis of infectious TB disease. 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 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	0 680			

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0 680	Continued From page 7 by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee's EPP dated May 1, 2024, lacked a policy and procedure for system to track the location of on-duty staff and sheltered residents. On May 23, 2024, at 12:06 p.m., licensed assisted living director (LALD)-C indicated licensee was not aware of the emergency preparedness plan requirement for a procedure on tracking staff. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780			

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0 780	Continued From page 8 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect residents in unit #1 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).	0 780			

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0 780	Continued From page 9 The findings include: During the facility tour on May 21, 2024, at 12:30 p.m. with the president(P)-G and property manager (PM)-H, survey staff observed the following items: 2409 1st Ave. S. It was observed the sleeping rooms in unit #1 on the first floor that were equipped with smoke alarms were not interconnected upon testing, so actuation of one alarm would cause all alarms to operate. During the interview on May 21,2024, at 1:30 p.m., P-G confirm that the smoke alarms in the unit were not interconnected, and the actuation of one alarm would cause all alarms to operate. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
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: The licensee failed to maintain the physical environment in a continuous state of good repair	0 800			

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0 800	Continued From page 10 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 of the residents). The findings include: On May 21, 2024, at 12:30 p.m., survey staff toured the facility with the president(P)-G and property manager (PM)-H. During the facility tour, survey staff observed the following items: 2401 1st Ave. S. In resident unit #15 on the first floor, it was observed that the window operating sash cord was broken, and the wooden double-hung window would not stay open when tested. In the bathroom on the second floor, the door closer was broken and hanging loose. The ceiling-mounted exhaust fan cover was also hanging below the finished ceiling. In the egress stair on the third floor, ripped wallpaper was observed on the wall, and brown stains were found on the sheetrock ceiling with evidence of water damage. During the facility tour at 12:30 p.m., P-G stated there was a water leak from the roof and verified these deficient findings at the time of discovery.	0 800			

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0 800	Continued From page 11 2405 1st Ave. S. In the kitchen on the lower level, it was observed there was a hole in the gypsum ceiling. 109 E. 24th Street In the egress stair by unit #40 on the second floor, it was observed that the fire-rated stair door did not close and self-latch when tested. That fire-rated door is required to self-latch to maintain the fire barrier from the corridor. In resident unit #42 on the second floor, it was observed that the door trim was loose and not securely attached to the wall, and sharp nails were exposed. 2409 1st Ave. S. In the egress stair by unit #2 on the first floor, a fire-rated stair door was observed propped open with a wood wedge. A fire-rated door is required to self-latch to maintain the fire barrier from the corridor, and the wedge will prevent the door from closing in the event of a fire. In the egress stair by unit #9 and the egress stair by unit #11 on the third floor, it was observed the fire-rated stair doors were propped open with a wood wedge. Those fire-rated doors are required to self-latch to maintain the fire barrier from the corridor, and the door wedge will prevent the door from closing in the event of a fire. In resident units #10 on the third floor, it was observed the fire-rated unit door did not close and self-latch when tested. The door is required to self close and latch to maintain the fire barrier of the room. During the facility tour, P-G visually verified these deficient findings at the time of discovery.	0 800			

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NAME OF PROVIDER OR SUPPLIER WHITTIER PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2405 1ST AVENUE SOUTH MINNEAPOLIS, MN 55404			
(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	
0 800	Continued From page 12	0 800			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide physical elements that did not constitute a distinct hazard to life by not providing properly sized egress windows in all resident sleeping rooms. This deficient condition had the ability to affect all staff and residents. 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	0 820	This immediate correction order identified on May 22, 2024, has had the immediacy lifted as of May 23, 2024, however non-compliance remained a scope and level of I.		

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0 820	Continued From page 13 portion or all of the residents). The findings include: On May 21, 2024, at 12:30 p.m., survey staff toured the facility with the president(P)-G and property manager (PM)-H. During the facility tour, survey staff observed the following items: 2401 1st Ave. S. It was observed that occupied resident bedroom #B1 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 17.5 inches in height and 35 inches in width, with a total openable area of 612.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedrooms #18, #19, and #21 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #18 - 20 inches in height and 27 inches in width, with a total openable area of 540 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #19 - 18.5 inches in height and 35 inches in width, with a total openable area of 647.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. - Bedroom #21- 20 inches in height and 25 inches in width, with a total openable area of 500 square inches. The windows did not meet the minimum requirements for total openable area.	0 820			

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0 820	Continued From page 14 It was observed that occupied resident bedrooms #25, #26, #28, #29, and #30 on the second floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #25 - 23 inches in height and 27 inches in width, with a total openable area of 621 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #26 - 22 inches in height and 27 inches in width, with a total openable area of 594 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #28 - 21 inches in height and 29 inches in width, with a total openable area of 609 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #29- 16.5 inches in height and 25 inches in width, with a total openable area of 412.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. - Bedroom #30- 23 inches in height and 26 inches in width, with a total openable area of 598 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that occupied resident bedrooms #31 and #32 on the third floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows measured 39 inches in height and 17 inches in width, with a total openable area of 663 square inches. The windows did not meet the minimum requirements for opening width.	0 820			

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0 820	Continued From page 15 2405 1st Ave. S. It was observed that occupied resident bedrooms #5, #6, #8, and #12 on the second floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #5 - 21 inches in height and 25 inches in width, with a total openable area of 525 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #6 - 20 inches in height and 29.5 inches in width, with a total openable area of 590 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #8- 22.5 inches in height and 27 inches in width, with a total openable area of 607.5 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #12- 20.5 inches in height and 27 inches in width, with a total openable area of 553.5 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom #13 on the third floor did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 37 inches in height and 19 inches in width, with a total openable area of 703 square inches. The windows did not meet the minimum requirements for opening width. It was observed that unoccupied resident bedroom #9 on the second floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as the	0 820			

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0 820	Continued From page 16 below. The clear openable area of the opened windows measured 21.5 inches in height and 27 inches in width, with a total openable area of 580.5 square inches. The windows did not meet the minimum requirements for opening width. It was observed that unoccupied resident bedroom #14 on the third floor did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 37 inches in height and 19 inches in width, with a total openable area of 703 square inches. The windows did not meet the minimum requirements for opening width. 109 E. 24th Street It was observed that occupied resident bedroom #B1 on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16 inches in height and 35 inches in width, with a total openable area of 560 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedrooms #33, #35, #36,#37, and #38 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #33 - 18 inches in height and 25 inches in width, with a total openable area of 450 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area.	0 820			

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0 820	Continued From page 17 - Bedroom #35 - 21 inches in height and 27 inches in width, with a total openable area of 567 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #36- 20.5 inches in height and 27.5 inches in width, with a total openable area of 563.75 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #37- 20.5 inches in height and 31 inches in width, with a total openable area of 635.5 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #38- 21 inches in height and 29 inches in width, with a total openable area of 609 square inches. The windows did not meet the minimum requirements for total openable area It was observed that occupied resident bedrooms #39, #40, #42, #43, and #45 on the second floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows were measured as below. - Bedroom #39 - 20 inches in height and 25 inches in width, with a total openable area of 500 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #40 - 24 inches in height and 26 inches in width, with a total openable area of 624 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #42 - 21 inches in height and 27 inches in width, with a total openable area of 569 square inches. The windows did not meet the minimum requirements for total openable area. - Bedroom #43 - 20 inches in height and 27 inches in width, with a total openable area of 540 square inches. The windows did not meet the	0 820			

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0 820	Continued From page 18 minimum requirements for total openable area. - Bedroom #45- 20 inches in height and 29 inches in width, with a total openable area of 580 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom #46 and #47 on the third floor did not have windows that met the minimum size requirements for egress escape. The clear openable areas of the opened windows measured 32 inches in height and 19 inches in width, with a total openable area of 608 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. 2409 1st Ave. S. It was observed that occupied bedroom A in the resident #2 on the first floor did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 23.5 inches in height and 27 inches in width, with a total openable area of 634.5 square inches. The windows did not meet the minimum requirements for total openable area. It was observed that occupied bedroom A in the resident #10 on the third floor did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 16 inches in height and 27 inches in width, with a total openable area of 432 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area.	0 820			

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0 820	Continued From page 19 Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to P-G that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. P-G verbally confirmed the findings. On May 21, 2024, at 4:00 p.m., during the interview, P-G stated the facility already had a contractor and ordered windows. They were currently in the permitting process with the City of Minneapolis. Survey staff explained to P-G that any construction or alternation in an assisted living facility does require a review and approval from MDH. On May 21, 2024, at 4:30 p.m., during the interview, survey staff explained to P-G that an immediate correction order was issued for the above finding. P-G acknowledged the above finding. TIME PERIOD FOR CORRECTION: Immediate On May 22, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	0 820			
0 970 SS=C	144G.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	0 970			

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0 970	Continued From page 20 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 that waived the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee's blank Customized Living Contract, undated, read under section 19. Liability, tenants are liable for any injury, death or property damage occurring in the apartment or on landlord's premises if such injury, death or property damage occurs as the result of tenant's respective negligent acts. On May 21, 2024, at 11:18 a.m., licensed assisted living director (LALD)-C stated another facility owned by the licensee had a citation for the liability language in the contract, but this was resolved as they feel the wording is not a waiver of liability.	0 970			

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0 970	Continued From page 21 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01370 SS=F	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 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;	01370			

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01370	Continued From page 22 (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 were completed for all required areas, prior to providing services, for three of three unlicensed personnel ((ULP)-D, ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on March 30, 2023, to provide direct care services to residents. ULP-D's record lacked training and competencies in the following required areas: - appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic	01370			

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01370	Continued From page 23 devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; and - standby assistance techniques and how to perform them. ULP-E ULP-E was hired on December 14, 2020, under the former comprehensive license and started to provide assisted living services to residents on August 1, 2021. ULP-E's record lacked training and competencies in the following required areas: - maintenance of a clean and safe environment; - 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. - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - understanding appropriate boundaries between staff and clients and the client's family; and - awareness of commonly used health technology equipment and assistive devices. ULP-F ULP-F was hired on April 11, 2022, to provide direct care services to residents. ULP-F's record lacked training and competencies in the following required areas: - appropriate and safe techniques in personal hygiene and grooming, including:	01370			

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01370	Continued From page 24 (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; (iv) dressing and assisting with toileting; and - standby assistance techniques and how to perform them. On May 22, 2024, at 1:50 p.m., licensed assisted living director (LALD)-C stated licensee provide required training but did not provide training and competencies on services and treatments their residents did not receive. LALD-C also stated none of the other ULPs received training in these required competencies. The Licensee's undated Team Member Training policy indicated the licensee would ensure Launch Day trainings, training scheduling assistants, training workbooks, new team member Bridge training program and annual trainings in Bridge stay in compliance with Minnesota Statute 144G (sections 60-64) as well as the applicable administrative rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	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	01380			

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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
01380	Continued From page 25 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 interview and record review, the licensee failed to ensure training and competency evaluations were completed for all required areas, prior to providing services, for three of three unlicensed personnel ((ULP)-D, ULP-E, ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on March 30, 2023, to provide direct care services to residents. ULP-D's record lacked training and competencies in the following required areas: - reading and recording temperature, pulse, and	01380			

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01380	Continued From page 26 respirations of the resident; - safe transfer techniques and ambulation; and - range of motioning and positioning. ULP-E ULP-E was hired on December 14, 2020, under the former comprehensive license and started to provide assisted living services to residents on August 1, 2021. ULP-E's record lacked training and competencies in the following required areas: - reading and recording temperature, pulse, and respirations of the client; - recognizing physical, emotional, cognitive, and developmental needs of the client; - safe transfer techniques and ambulation; and - range of motioning and positioning. ULP-F ULP-F was hired on April 11, 2024, to provide direct care services to residents. ULP-F's record lacked training and competencies in the following required areas: - safe transfer techniques and ambulation; and - range of motioning and positioning. On May 22, 2024, at 1:50 p.m., licensed assisted living director (LALD)-C stated the licensee provide required training but did not provide training and competencies on services and treatments their residents did not receive. LALD-C also stated none of the other ULPs received training in these required competencies. The Licensee's undated Team Member Training policy indicated the licensee would ensure Launch Day trainings, training scheduling assistants, training workbooks, new team	01380			

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01380	Continued From page 27 member Bridge training program and annual trainings in Bridge stay in compliance with Minnesota Statute 144G (sections 60-64) as well as the applicable administrative rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	01440			

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01440	Continued From page 28 Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) provided direct supervision of staff performing delegated tasks within 30 calendar days after the task was delegated and thereafter as needed based on performance for two of two unlicensed personnel ((ULP)-D, ULP-E). 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: ULP-D ULP-D was hired on March 30, 2023, to provide direct care services to residents. On May 21, 2024, at 8:10 a.m., the surveyor observed ULP-D administer medications to the licensee's residents in the medication office. ULP-E ULP-E was hired on December 14, 2020, under the former comprehensive license and started to provide assisted living services to residents on August 1, 2021. On May 21, 2024, between 7:56 a.m., and 8:50 a.m., the surveyor observed ULP-E administer medications to the licensee's residents in the medication office. ULP-D and ULP-E's employee records lacked	01440			

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01440	Continued From page 29 direct supervision performing delegated tasks within 30 calendar days after the date on which ULP-D and ULP-E first performed delegated tasks for residents and thereafter as needed based on performance. On May 22, 2024, at 2:05 p.m., licensed assisted living director (LALD)-C stated supervision happens if a ULP has an issue that will need close supervision. The licensee lacked any documentation of ULP supervision. The licensee's undated Nursing Supervisory Visits of Advocate & HHA Staff policy indicated nurses were to periodically assess a team members ability to deliver services through direct observation of the service delivery when a team member is new to the facility and ideally quarterly; and to discuss with direct supervisor. The policy lacked a process for direct supervision of staff performing delegated tasks within 30 calendar days after the task was delegated and a process for documenting the direct supervision. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of	01500			

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01500	Continued From page 30 vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased	01500			

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01500	Continued From page 31 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for two of three employees (unlicensed personnel (ULP)-D, ULP-E). 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: ULP-D ULP-D was hired on March 30, 2023, to provide direct care services to residents. ULP-D's employee record lacked evidence annual training had been completed as required in the following area: -Principles of person-centered planning/service delivery.	01500			

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01500	Continued From page 32 ULP-E ULP-E was hired on December 14, 2020, under the former comprehensive license and started to provide assisted living services to residents on August 1, 2021. ULP-E's employee record lacked evidence annual training had been completed as required in the following areas: - Assisted Living bill of rights; and - Review of provider's policies and procedures. On May 22, 2024, at 2:40 p.m., licensed assisted living director (LALD)-C stated, "Most of those (courses) are reassigned each year and we are in the process of getting that reassigned for everyone." Also, LALD-C stated ULP-E had probably not been assigned annual training and was not sure if any more staff would be missing their annual training. The Licensee's undated Team Member Training policy indicated licensee would ensure Launch Day trainings, training scheduling assistants, training workbooks, new team member Bridge training program and annual trainings in Bridge stay in compliance with Minnesota Statute 144G (sections 60-64) as well as the applicable administrative rules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy	01790			

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01790	Continued From page 33 is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the	01790			

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01790	Continued From page 34 medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed training and competencies for unlicensed personnel (ULP) providing medications to residents for unplanned time away from home when the licensed nurse was not available for two of two employees (ULP-D, ULP-E). 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:	01790			

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01790	Continued From page 35 ULP-D ULP-D was hired on March 30, 2023, to provide direct care services to residents. On May 21, 2024, at 8:10 a.m., the surveyor observed ULP-D administer medications to the licensee's residents in the medication office. ULP-E ULP-E was hired on December 14, 2020, under the former comprehensive license and started to provide assisted living services to residents on August 1, 2021. On May 21, 2024, at 7:56 a.m., the surveyor observed ULP-E pack unplanned leave of absence medications for R6. ULP-E stated R6 was leaving that morning for three days and needed his medications to go with. ULP-D and ULP-E's record lacked evidence they received training and deemed competent for unplanned time away when the RN was not available. The record also lacked evidence the RN had developed a written procedure for the unlicensed personnel that addressed: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident,	01790			

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01790	Continued From page 36 and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. On May 22, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-B stated the licensee had completed the training and competency for newer staff. Also, licensed assisted living director (LALD)-C stated older staff would be missing competencies as the licensee had not developed them at the time of hire. The Licensee's undated Team Member Training policy indicated the licensee would ensure Launch Day trainings, training scheduling assistants, training workbooks, new team member Bridge training program and annual trainings in Bridge stay in compliance with Minnesota Statute 144G (sections 60-64) as well as the applicable administrative rules. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			

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01890	Continued From page 37	01890			
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure expired medications were disposed of for nine of nine residents (R3, R7, R8, R9, R10, R11, R12, R13, R14). 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 May 21, 2024, at 7:51 a.m., the surveyor observed the licensee's medication cart in Amity house which included the following expired medications: R3 - docusate sodium capsules 100 milligram (mg) take 1 capsule by mouth twice daily as needed for constipation expired April 23, 2024; and - famotidine tablets 20 mg take 1 tablet by mouth twice daily as needed for heartburn expired April	01890			

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01890	Continued From page 38 23, 2024. R8 - SM Alcohol prep 70% Pad use as directed every week expired on May, 2023. R9 - ondansetron tablet 4 mg take 1 tablet by mouth three times daily as needed for nausea and vomiting expired April 28, 2024. R10 - Two bubble packs of ibuprofen tablet 600 mg take one tablet by mouth every six hours as needed for pain expired May 17, 2024. R11 - haloperidol tablet 10 mg take one tablet by mouth up to three times daily as needed expired April 5, 2024. R12 - banophen tablets 25 mg take one tablet by mouth every six hours as needed (lip swelling) expired January 24, 2024. On May 21, 2024, at 9:25 a.m., the surveyor observed the licensee's medication cart in Serenity house which included the following expired medications for: R7 - trazodone tablets 100 mg take 1-2 tablets by mouth at bedtime expired April 10, 2024. R13 - melatonin tablet 3 mg take one tablet by mouth at bedtime expired May 2, 2024; and - prochlorperazine tablet 10 mg take one tablet every 8 hours as needed expired March 23, 2024.	01890			

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01890	Continued From page 39 R14 - two bottles of trazodone tablets 100 milligram (mg) take one tablet by mouth at bedtime expired May 17, 2024. and April 12, 2024; and - bupropion 150 mg XL tablet take three tablets by mouth expired March 13, 2024. On May 21, 2024, at 10:00 a.m., unlicensed personnel (ULP)-E stated they would remove expired medications when they catch them. Also, ULP-E stated nurses come around to audit medication carts but was not sure how often. On May 22, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C stated the registered nurse (RN) was responsible for medication cart audits monthly. The licensee's undated Nursing Facility Visit Process policy indicated during a facility visit the nurse would ensure overall organization with medication storage. The licensee's undated Facility Visit Checklist identified expired medications under Medication Storage as pass or fail. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2024
NAME OF PROVIDER OR SUPPLIER WHITTIER PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 2405 1ST AVENUE SOUTH MINNEAPOLIS, MN 55404			
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01910	Continued From page 40 part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication with all the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 was discharged from the licensee on April 30, 2024.	01910			

Minnesota Department of Health

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01910	Continued From page 41 R1's discharge note dated May 13, 2024, indicated R1 received medication management services. The note also indicated R1 did not take medications with them as they were discharged from a hospital to a treatment program. R1's record lacked the following required content for disposition of medication: - medication's name; - strength; - prescription number as applicable; - quantity; - to whom the medications were given; - date of disposition; and - names of staff and other individuals involved in the disposition. On May 22, 2024, at 2:20 p.m., director (D)-A stated the licensee had not completed medication disposition as the resident was discharged from the hospital to a treatment center. When the surveyor inquired what happened to R1's medications, D-A stated the licensee's staff had disposed of them. The licensee's Customized Living Discharge Process policy indicated medications may be returned to the client at the time of discharge or the discontinuation of medication services. When meds are returned to a client, the licensee must maintain written confirmation of what was handed off. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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01940	Continued From page 42	01940			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R5) with blood glucose	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30820	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/22/2024
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01940	Continued From page 43 management. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R5's diagnoses included paranoid schizophrenia, type 2 diabetes, and hypertension. R5's Service Plan dated December 22, 2023, indicated R5 received the following services: meal assistance, home management, activities of daily living, mental health management, and medication administration. R5's Medication and Treatment Management Plan dated November 24, 2023, indicated under section diabetic protocol - is the resident diabetic? the box checked indicated no. R5's Nursing Assessment dated April 18, 2024, indicated under section endocrine R5 had a diagnosis of type 2 diabetes and was well managed with medications. R5's Medication Administration Record (MAR) dated between May 1, 2024, and May 22, 2024, indicated check and record blood glucose four times daily. R5's blood glucose ranges were between 207 milligram/deciliter (mg/dl) and 585 mg/dl.	01940			

Minnesota Department of Health

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01940	Continued From page 44 R5's treatment and therapy management plan lacked the following content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On May 22, 2024, at 2:40 p.m., registered nurse (RN)-B stated they thought the information was available in R5's nursing assessment and MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be	01970			

Minnesota Department of Health

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01970	Continued From page 45 renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded prescriber's orders were maintained for one of one resident (R2) with blood glucose (BG) monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R5's diagnoses included paranoid schizophrenia, type 2 diabetes, and hypertension. R5's Service Plan dated December 22, 2023, indicated R5 received the following services: meal assistance, home management, activities of daily living, mental health management, and medication administration. R5's Medication and Treatment Management Plan dated November 24, 2023, indicated under section diabetic protocol - is the resident diabetic? the box checked indicated no. R5's Nursing Assessment dated April 18, 2024, indicated under section endocrine R5 had a diagnosis of type 2 diabetes and was well managed with medications.	01970			

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01970	Continued From page 46 R5's Medication Administration Record (MAR) dated between May 1, 2024, and May 22, 2024, indicated check and record blood glucose four times daily. R5's blood glucose ranges were between 207 milligram/deciliter (mg/dl) and 585 mg/dl. R5's record lacked a current signed order for BG monitoring. On May 22, 2024, at 2:40 p.m., registered nurse (RN)-B stated they thought they had received R5's BG orders in their fax portal, but when they checked they could not find the orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			



Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Full
Date: 05/21/24
Time: 10:00:00
Report: 1047241118

Food and Beverage Establishment Inspection Report

Page 1

Location:

Whittier Place
2405 1st Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0039346
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128721983
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3 comp sink dispenser
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Beverage air- pasta salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Beverage air- milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: Double door upright- potato salad
Violation Issued: No

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

Inspection conducted with operator. Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

Operator is currently undergoing the class to get their CFPM. Additional information was provided with

Type: Full
Date: 05/21/24
Time: 10:00:00
Report: 1047241118
Whittier Place

Food and Beverage Establishment Inspection Report

Page 2

report.

Facility does not prepare meals on site- food is prepared at the central SLS kitchen in White Bear & transported to this facility pre-made. Staff at this facility serve & portion the received food. Receiving procedures & temperatures were discussed at time of inspection.

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 1047241118 of 05/21/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Lisa Jones-Lee
PIC

Signed: _____

Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us