Electronically Delivered

August 10, 2022

Administrator
Amy Johnson Residence
89 Virginia Street
Saint Paul, MN 55102

RE: Project Number(s) SL30229015

Dear Administrator:

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

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

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

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

| Please address your cover letter for general reconsideration requests to: | Free from Maltreatment reconsideration requests should be addressed to: |
|---|---|

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

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

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

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

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

Sincerely,

Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791| Fax: 218-332-5196

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30229 | A. BUILDING: _____ B. WING _____ | 07/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

| (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 |
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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br>SL30229015<br><br>On July 11, 2022, through July 12, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 19 residents receiving services under the provider's Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all 19 current residents of the facility.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the additional documentation | 0 480 | | |

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| 0 480 | Continued From page 2<br>included in the Food and Beverage Establishment Inspection Reports, dated July 11, 2022.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to implement and follow Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH) infection control guidance recommendations for eye protection for health care workers related to COVID-19. In addition, the licensee failed to ensure infection control practices were maintained during medication administration. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 510 | | |

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| 0 510 | Continued From page 3 | 0 510 | | |

client'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 clients).

The findings include:

On July 11, 2022, the BeReadyMN website indicated the licensee's county COVID-19 levels were at medium.

On July 11, 2022, at approximately 8:50 a.m., unlicensed personnel (ULP)-B passed medication in the medication room with her mask below the nose and without eye protection.

On July 11, 2022, at approximately 10:30 a.m., activities director (AD)-F sat with residents for an activity with their mask below the nose and without eye protection.

On July 12, 2022, at approximately 7:45 a.m., ULP-E prepared resident medications for administration, ULP-E opened medication carts, touched surfaces and moved chair and continued working with resident medications without washing hands.

The MDH COVID-19 PPE and Source Control Grids For Congregate Care Settings, by Community Transmission Level dated April 7, 2022, indicated staff should wear source control PPE when they are in areas of the health care facility where they could encounter residents.

On July 12, 2022, at approximately 12:20 p.m., registered nurse (RN)-A acknowledged the observations and stated all employees are trained to observe infection control measures. RN-A also

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| 0 510 | Continued From page 4<br>stated the licensee will remind all employees the importance of maintaining infection control standards.<br><br>The licensee's undated Standard Precautions for Infection Control policy indicated standard precautions apply to all patients regardless of their diagnosis but did not include verbiage to include the use and procedures for personal protective equipment for infection control.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure, the name, telephone number, and e-mail contact information for the individuals who are | 0 550 | | |

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| 0 550 | Continued From page 5<br>responsible for handling resident grievances.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On July 11, 2022, at approximately 10:20 a.m., during a facility tour, the surveyor observed the licensee lacked a posting in a conspicuous place with information about the licensee's grievance procedure with required content.<br><br>On July 11, 2022, at approximately 11:05 a.m., registered nurse (RN)-B acknowledged the required content had not been posted. RN-B also stated the licensee will post the required information.<br><br>The licensee's undated Complaint policy and procedure indicated the licensee will inform residents as to how to file a complaint with the Office of Health Facility Complaints and Ombudsman for Long Term Care. The policy lacked to the above missing information.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 550 | | |

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| 0 570 | Continued From page 6 | 0 570 | | |
| 0 570 SS=F | 144G.42 Subdivision 1 Display of license<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to display the current assisted living license at the main entrance of the assisted living building.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During an observation on July 11, 2022, from approximately 10:15 a.m., to 10:30 a.m., the surveyor did not observe an original current license posted at entrances, hallways, dining areas, or in living areas of the facility.<br><br>On July 11, 2022, at approximately 11:15 p.m., program director (PM)-D acknowledged the current license was not posted in common area and stated the licensee had a current assisted living license dated for August 1, 2021, but the license had not been posted as of yet. PM-D also stated the license was in office and they will post it. | 0 570 | | |

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| 0 570 | Continued From page 7<br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 570 | | |
| 0 580 SS=F | 144G.42 Subd. 2 Quality management<br><br>The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the licensee and relevant to the type of services provided. This had the potential to affect all current residents, staff and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 | 0 580 | | |

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| 0 580 | Continued From page 8<br>portion or all of the residents).<br><br>The findings include:<br><br>On July 11, 2022, at approximately 9:50 a.m., during the entrance conference with registered nurse (RN)-A and program director (PD)-D, a request was made to review documentation of the licensee's quality management activities.<br><br>On July 11, 2022, at approximately 10:30 a.m., RN-A and PD-D acknowledged the licensee did not have documentation of ongoing quality management activities relevant to the size and services provided. RN-A also stated staff meet to discuss improvement to cares but no documentation was maintained.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 580 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language. | 0 640 | | |

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| 0 640 | Continued From page 9<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 19 residents receiving assisted living services.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients)<br><br>The findings include:<br><br>On July 11, 2022, at approximately 10:20 a.m., during a facility tour, the surveyor did not observe a posting of the emergency number in the facility's common areas and near telephones provided by the assisted living facility.<br><br>During an interview on July 11, 2022, at approximately 10:55 a.m., registered nurse (RN)-A acknowledged the required emergency number was not posted in the common areas of the facility.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 640 | | |

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| 0 650 | Continued From page 10 | 0 650 | | |
| 0 650 SS=D | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br>(b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure an employee record included all the required content for one of one employee (unlicensed personnel (ULP)-B) | 0 650 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 30229 | A. BUILDING: _____ B. WING _____ | 07/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

| (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 |
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| 0 650 | Continued From page 11<br>with employee record reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-B started employment on July 20, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>On July 12, 2022, at approximately 8:10 a.m., ULP-B passed medications to R1.<br><br>ULP-B's record lacked content of orientation to include:<br>- Overview of assisted living statutes<br>- Review of provider's policies and procedures<br>- Assisted living bill of rights<br>- Review of types of assisted living services the employee will provide and provider's scope of license<br>- Principles of person-centered planning/service delivery<br><br>On July 12, 2022, at approximately 12:30 p.m., registered nurse (RN)-A acknowledged ULP-B's record was missing required content. In addition, RN-A stated that ULP-B had finished all required training, but RN-A did not understand how the employee record was missing it. | 0 650 | | |

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| 0 650 | Continued From page 12<br><br>The licensee's undated Employee Orientation policy indicated the licensee provided an appropriate orientation and ongoing staff training for all its employees.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 650 | | |
| 0 660 SS=F | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(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.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on 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 completing a TB Facility Risk Assessment, and ensuring TB training was | 0 660 | | |

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| 0 660 | Continued From page 13<br>completed for one of two employees (unlicensed personnel (ULP)-B) with records reviewed. This had the potential to affect all licensee residents, and staff.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>TB RISK ASSESSMENT<br>The licensee failed to complete a TB risk assessment, including designating and documenting a qualified person or team with primary responsibility for the TB infection control program.<br><br>On July 12, 2022, at approximately 1:30 p.m. registered nurse (RN)-A acknowledged the licensee had not completed a TB risk assessment as required.<br><br>TB TRAINING<br>ULP-B started employment on July 20, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>ULP-B's employee record included a TB history and symptom screening form dated May 24, 2021, and documentation of TB baseline screening test results dated May 24, 2021, and June 22, 2021, respectively. | 0 660 | | |

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| 0 660 | Continued From page 14<br><br>ULP-B's employee record lacked TB training completed at hire.<br><br>The Minnesota Department of Health (MDH)'s Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013 noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan.<br><br>On July 12, 2022, at approximately 9:39 a.m., registered nurse (RN)-A acknowledged ULP-B's employee record lacked TB training prior to her hire date.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding | 0 680 | | |

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| 0 680 | Continued From page 15<br>missing tenant residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect all 19 residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On July 12, 2022, at approximately 10:00 a.m., the surveyor requested to review the licensee's emergency preparedness plan, which the licensee never provided.<br><br>The licensee lacked a written emergency disaster plan that contained the following:<br>- Establishment of the Emergency Program (EP) | 0 680 | | |

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| 0 680 | Continued From page 16<br>- Develop and Maintain EP Program<br>- Maintain and Annual EP Updates<br>- EP Program Patient Population<br>- Process for EP Collaboration<br>- Development of EP Policies and Procedures<br>- Subsistence Needs for Staff and Patients<br>- Procedures for Tracking of Staff and Patients<br>- Policies and Procedures Including Evacuation<br>- Policies and Procedures for Sheltering<br>- Policies and Procedures for Medical Documents<br>- Policies and Procedures for Volunteers<br>- Arrangement with Other Facilities<br>- Roles under a Waiver Declared by Secretary<br>- Development of Communication Plan<br>- Names and Contact Information<br>- Emergency Officials Contact Information<br>- Primary/Alternate Means for Communication<br>- Methods for Sharing Information<br>- Sharing Information on Occupancy/Needs<br>- LTC Family Notifications<br>- Emergency Prep Training and Testing<br>- Emergency Prep Training Program<br>- Emergency Prep Testing Requirements<br>- LTC Emergency Power (Typically ENGINEERING)<br>- Integrated Health Systems<br><br>On July 12, 2022, at 10:30 a.m., registered nurse (RN)-A acknowledged the licensee did not have an emergency preparedness plan. RN-A also stated the licensee's management staff have talked about it and will implement it.<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |

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| 0 780 | Continued From page 17 | 0 780 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 780 | | |

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| 0 780 | Continued From page 18<br>resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).<br><br>The findings include:<br><br>On July 12, 2022, between 11:45 a.m. and 1:30 p.m., survey staff toured the facility with H-M. During the facility tour, survey staff observed smoke alarms were not interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required.<br><br>H-M verbally confirmed survey staff observations during the facility tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 780 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and | 0 790 | | |

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| 0 790 | Continued From page 19<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).<br><br>The findings include:<br><br>On July 12, 2022, between 11:45 a.m. and 1:30 p.m., survey staff toured the facility with H-M. During the facility tour, survey staff observed the fire extinguishers are not monthly checked by staff.<br><br>H-M verbally confirmed survey staff observations during the facility tour.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 900 SS=F | 144G.50 Subdivision 1 Contract required<br><br>(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written | 0 900 | | |

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| 0 900 | Continued From page 20<br>contract with the resident.<br><br>(b) The contract must contain all the terms concerning the provision of:<br>(1) housing;<br>(2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and<br>(3) the resident's service plan, if applicable.<br><br>(c) A facility must:<br>(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and<br>(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.<br><br>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.<br><br>(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.<br><br>(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and execute a written contract with the required content for three of three residents (R1, R2, R3) with records | 0 900 | | |

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| 0 900 | Continued From page 21<br>reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R1 was admitted to licensee on July 1, 2019, and started receiving assisted living services on August 1, 2021.<br><br>R1's service plan dated August 17, 2021, indicated R1 was receiving the following services: housekeeping, laundry, medication administration, monitoring, blood glucose monitoring, vital signs, safety checks, bathing, and symptom screening.<br><br>R2 was admitted to licensee on April 6, 2021, and started receiving assisted living services on August 1, 2021.<br><br>R2's service plan dated August 17, 2021, indicated R2 was receiving the following services: housekeeping, laundry, linen change, medication administration, monitoring, nail care, RN assessment, CPAP cleaning and maintenance, vital signs, safety checks, bathing, dining services, toileting, and symptom screening.<br><br>R3<br>R3 was admitted to licensee on July 16, 2009, and started receiving assisted living services on | 0 900 | | |

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| 0 900 | Continued From page 22<br>August 1, 2021.<br><br>R3's service plan dated August 17, 2021, indicated R3 was receiving the following services: activities of daily living assist, behavior, housekeeping, laundry, medication administration, socialization, RN assessment, vital signs, safety checks, bathing, dining services, and symptom screening.<br><br>R1, R2 and R3's records lacked a written contract which included all of the terms concerning the provisions of the following as required:<br>(1) housing<br>(2) assisted living services, whether provided directly by the licensee or by management agreement or other agreement; and<br>(3) the resident's service plan, if applicable.<br><br>In addition, R1, R2 and R3's records lacked evidence the contract had been fully executed as the licensee must:<br>- offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract;<br>- give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and<br>- the licensee must offer the resident the opportunity to identify a designated representative.<br><br>On July 11, 2022, at approximately 2:10 p.m., registered nurse (RN)-A acknowledged the licensee had not executed a written contract with all the licensee's residents. RN-A also stated the licensee will work to execute a written contract with the residents as soon as possible. | 0 900 | | |

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| 0 900 | Continued From page 23<br><br>No additional information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 900 | | |
| 01330 SS=D | 144G.60 Subd. 4 (b) Unlicensed personnel<br><br>(b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:<br>(1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;<br>(2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or<br>(3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure employee training and competency was completed, to include all required content, for one of one employee (unlicensed personnel (ULP)-B) with employee record reviewed.<br><br>This practice resulted in a level two violation (a | 01330 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

| (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 |
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| 01330 | Continued From page 24<br>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-B was hired July 20, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>On July 12, 2022, at approximately 7:45 a.m., ULP-B prepared R1 for shower.<br><br>ULP-B's employee file lacked documentation of training and competency evaluations for the following topics:<br>- maintenance of a clean and safe environment<br>- appropriate and safe techniques in personal hygiene and grooming, including:<br>- hair care and bathing<br>- care of teeth, gums, and oral prosthetic devices<br>- dressing and assisting with toileting<br>- basic nutrition, meal preparation, food safety, and assistance with eating<br>- preparation of modified diets as ordered by a licensed health professional<br>- communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family<br>- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel | 01330 | | |

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| 01330 | Continued From page 25<br>- range of motioning and positioning<br><br>On July 12, 2022, at approximately 1:42 p.m., registered nurse (RN)-A acknowledged ULP-B's employee record lacked documentation of the above training topics and competencies. RN-A verified ULP-B had no additional training documentation.<br><br>The licensee's undated Employee Orientation policy indicated the licensee provided an appropriate orientation and ongoing staff training for all its employees but lacked verbiage to include training and competency evaluation.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01330 | | |
| 01440 SS=D | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(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.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the | 01440 | | |

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| 01440 | Continued From page 26<br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-B) with employee record reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-B was hired July 20, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>On July 12, 2022, at approximately 8:10 a.m., ULP-B passed morning medications to R1.<br><br>ULP-B's record did not include documentation of direct supervision by an RN within 30 days of ULP-B performing delegated nursing tasks, including medication administration. | 01440 | | |

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| 01440 | Continued From page 27<br><br>On July 12, 2022, at approximately 1:42 p.m., registered nurse (RN)-A acknowledged ULP-B's employee record lacked documentation of direct supervision of ULP-B performing delegated tasks provided within 30 calendar days after the date on which the ULP-B began working for the licensee and first performed delegated tasks for residents and thereafter as needed based on performance.<br><br>The licensee's undated Employee Orientation policy indicated the licensee provided an appropriate orientation and ongoing staff training for all its employees but lacked verbiage to include supervision of unlicensed personnel performing delegated tasks.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01440 | | |
| 01530 SS=F | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial | 01530 | | |

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| 01530 | Continued From page 28<br>eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and record review, the licensee failed to ensure direct care staff received the required amount of dementia care training in the required time frame for one of one employee (unlicensed personnel (ULP)-B) with record reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>ULP-B was hired July 20, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.<br><br>ULP-B's employee record included a web based Approaching Care for Dementia training dated July 20, 2020, for 1.6 contact hours. | 01530 | | |

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| 01530 | Continued From page 29<br><br>ULP-B's record lacked documentation of the required eight (8) hours of dementia training within 120 working hours of the employment start date.<br><br>On July 12, 2022, at approximately 10:45 a.m., program director (PM)-D acknowledged ULP-B's record lacked the required 8 hours of dementia training within 120 working hours of the employment start date. PM-D also stated licensee was not aware of the 8 hours dementia training requirement, and so will have to update all employee records to reflect the statute requirement.<br><br>The licensee's undated Employee Orientation policy indicated the licensee provided an appropriate orientation and ongoing staff training for all its employees but lacked verbiage to include requirement for dementia training.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 01530 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision | 01620 | | |

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| 01620 | Continued From page 30<br>9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conduct ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of three residents (R2) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2 was admitted to licensee on April 6, 2021, and started receiving assisted living services on | 01620 | | |

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| 01620 | Continued From page 31<br>August 1, 2021.<br><br>R2's diagnoses included schizophrenia paranoid type, depression, severe obstructive sleep apnea, and peripheral vascular disease.<br><br>R2's service plan dated August 17, 2021, indicated R2 was receiving the following services: housekeeping, laundry, linen change, medication administration, monitoring, nail care, RN assessment, CPAP cleaning and maintenance, vital signs, safety checks, bathing, dining services, toileting, and symptom screening.<br><br>R2's record included documentation of comprehensive nursing assessments completed on April 11, 2021, August 16, 2021, and May 25, 2022, respectively. The ongoing resident monitoring and reassessment exceeded 90 calendar days from the date of the last review by 37 days and 192 days respectively.<br><br>On July 12, 2022, at approximately 12:20 p.m., RN-A acknowledged all R2's monitoring and reassessments exceeded 90 calendar days from the date of the last review. RN-A also stated he had just started working with licensee and so was not aware how the monitoring and assessment was completed in the past.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01690 SS=F | 144G.71 Subdivision 1 Medication management services<br><br>(a) This section applies only to assisted living | 01690 | | |

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| 01690 | Continued From page 32<br>facilities that provide medication management services.<br>(b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.<br>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop, implement, and maintain current medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current | 01690 | | |

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| 01690 | Continued From page 33<br>practice standards and guidelines.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on July 11, 2022, at approximately 9:05 a.m., RN-A confirmed the licensee provided medication management services to the licensee's residents.<br><br>On July 12, 2022, at approximately 8:10 a.m., unlicensed personnel (ULP)-B administered morning medications to R1 and R3.<br><br>On July 12, 2022, at approximately 12:40 p.m., the surveyor requested the licensee's medication management services policies and procedures. Program director (PM)-D provided the surveyor with a three ringed binder which had only one policy titled Medication and Treatment Orders but none of the other documents in the binder were customized to the licensee's operations.<br><br>The licensee's binder lacked written policies and procedures to address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving | 01690 | | |

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| 01690 | Continued From page 34<br>medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures to identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.<br><br>On July 12, 2022, at approximately 2:20 p.m., RN-A acknowledged the licensee was lacking medication management policies and procedures and stated the licensee was in the process of developing their policies and procedures.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01690 | | |
| 01790 SS=F | 144G.71 Subd. 10 Medication management for residents who will<br><br>(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;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to | 01790 | | |

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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 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

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| 01790 | Continued From page 36 | 01790 | | |

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 one of one unlicensed personnel ((ULP)-E) was trained and had demonstrated competency to prepare and give medications for resident having unplanned time away.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

During the entrance conference on July 11, 2022, at approximately 9:05 a.m., registered nurse (RN)-A confirmed the licensee provided medication management services to the licensee's residents.

On July 12, 2022, at approximately 7:20 a.m., ULP-E prepared and handed over medications for a leave of absence (LOA) to R5. ULP-E stated the medications were packed by the night staff, but she had to counter check before handing them over to R5.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30229 | A. BUILDING: _____ B. WING _____ | 07/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

| (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 |
|---|---|---|---|---|
| 01790 | Continued From page 37<br><br>ULP-E's employee record lacked RN documentation that ULP-E had been trained and determined competent to follow the procedures for LOA medications.<br><br>On July 12, 2022, at approximately 11:10 a.m., RN-A acknowledged all the licensee's unlicensed personnel lacked documentation in employee records for LOA medication training. RN-A also stated the previous nurse had trained the staff, but documentation was missing.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |
| 01820 SS=D | 144G.71 Subd. 13 Prescriptions<br><br>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure currently written or electronically recorded prescriptions were obtained for two of three residents (R1, R2) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and | 01820 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30229 | A. BUILDING: _____ B. WING _____ | 07/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

| (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 |
|---|---|---|---|---|
| 01820 | Continued From page 38 | 01820 | | |

was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R1
R1 was admitted to the licensee on July 1, 2019, and started receiving assisted living services on August 1, 2021.

R1's service plan dated August 17, 2021, indicated R1 was receiving the following services: housekeeping, laundry, medication administration, monitoring, blood glucose monitoring, vital signs, safety checks, bathing, and symptom screening.

R1's unsigned provider orders dated September 28, 2021, indicated R1 was receiving the following medications:
- aspirin 81 milligram (mg) by mouth daily
- atropine sulphate 1% solution place two drops in under the tongue twice daily
- basaglar kwikpen 100 unit/milliliter (ml) inject 20 units subcutaneously at bedtime
- clozapine 200 mg tablet take two tablets by mouth daily at bedtime
- glipizide 10 mg extended release (ER) take one tablet by mouth daily
- lisinopril 2.5 mg tablet take one tablet daily
- olanzapine 5 mg take one tablet by mouth daily
- tamsulosin 0.4 mg take two capsules by mouth once daily.

R2
R2 was admitted to the licensee on April 6, 2021, and started receiving assisted living services on

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30229 | A. BUILDING: _____ B. WING _____ | 07/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

| (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 |
|---|---|---|---|---|
| 01820 | Continued From page 39<br>August 1, 2021.<br><br>R2's service plan dated August 17, 2021, indicated R2 was receiving the following services: housekeeping, laundry, linen change, medication administration, monitoring, nail care, registered nurse (RN) assessment, continuous positive airway pressure (CPAP) machine (a machine that is used to treat sleep apnea) cleaning and maintenance, vital signs, safety checks, bathing, dining services, toileting, and symptom screening.<br><br>R2's signed provider orders dated September 17, 2019, indicated R2 was receiving the following medications:<br>- divalproex 500 mg take two tablets by mouth at bedtime<br>- haloperidol 10 mg take one tablet twice a day<br>- lorazepam 0.5 mg take one tablet twice daily<br>- olanzapine 20 mg take two tablets at bedtime daily<br>- venlafaxine 150 mg take one capsule once daily.<br><br>R1 and R2's records lacked current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16a, for all prescribed medications that the licensee was managing for the residents and renewed at least every 12 months or more frequently as indicated by the assessment.<br><br>On July 12, at approximately 12:05 p.m., RN-A acknowledged R1 and R2's records were missing current written or electronically recorded prescription and stated the licensee will update the orders as soon as possible.<br><br>No further information was provided. | 01820 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30229 | A. BUILDING: _____ B. WING _____ | 07/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

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|---|---|---|---|---|
| 01820 | Continued From page 40<br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01820 | | |
| 01930 SS=F | 144G.72 Subd. 2 Policies and procedures<br><br>(a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.<br>(b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems | 01930 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

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|---|---|---|---|---|
| 01930 | Continued From page 41<br>are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on July 11, 2022, at approximately 9:20 a.m., registered nurse (RN)-A stated the licensee provided treatment management services.<br><br>On July 11, 2022, at approximately 11:25 a.m., RN-A provided the surveyor with the licensee's policies and procedure manual, but it lacked treatment or therapy management policies and procedures.<br><br>On July 11, 2022, at approximately 12:00 p.m., RN-A acknowledged and confirmed the licensee failed to develop, implement, and maintain the following required policies:<br>- written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities<br>- educating and communicating with residents about treatments or therapies they are receiving<br>- monitoring and evaluating the treatment or therapy<br>- communicating with the prescriber.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01930 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 30229 | A. BUILDING: _____ B. WING _____ | 07/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

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|---|---|---|---|---|
| 01940 | Continued From page 42<br><br>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:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R1, R2) with records reviewed. | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| 01940 | Continued From page 43<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1<br>R1 was admitted to the licensee on July 1, 2019, and started receiving assisted living services on August 1, 2021.<br><br>R1's service plan dated August 17, 2021, indicated R1 was receiving the following services: housekeeping, laundry, medication administration, monitoring, blood glucose monitoring, vital signs, safety checks, bathing, and symptom screening.<br><br>R1's daily blood glucose monitoring record dated between July 1, 2022, and July 10, 2022, indicated R1's blood sugar levels ranged between 171 and 224.<br><br>R1's record lacked a treatment or therapy management plan to include the following content:<br>- a statement of the type of services that will be provided;<br>- documentation of specific resident instructions relating to the treatments or therapy administration;<br>- identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>- procedures for notifying a registered nurse or | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 30229 | A. BUILDING: _____ B. WING _____ | 07/12/2022 |

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| AMY JOHNSON RESIDENCE | 89 VIRGINIA STREET SAINT PAUL, MN 55102 |

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|---|---|---|---|---|
| 01940 | Continued From page 44 | 01940 | | |

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.

R2
R2 was admitted to the licensee on April 6, 2021, and started receiving assisted living services on August 1, 2021.

R2's service plan dated August 17, 2021, indicated R2 was receiving the following services: housekeeping, laundry, linen change, medication administration, monitoring, nail care, registered nurse (RN) assessment, continuous positive airway pressure (CPAP) machine (a machine that is used to treat sleep apnea) cleaning and maintenance, vital signs, safety checks, bathing, dining services, toileting, and symptom screening. R2's undated individual treatment and therapy plan indicated R2 was receiving CPAP cleaning and maintenance weekly on Thursdays

R2's record lacked a treatment or therapy management plan to include the following content:
- 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30229 | A. BUILDING: _____ B. WING _____ | 07/12/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **AMY JOHNSON RESIDENCE** | **89 VIRGINIA STREET SAINT PAUL, MN 55102** |

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| 01940 | Continued From page 45<br>complications or adverse reactions.<br><br>On July 12, 2022, at approximately 1:40 a.m., RN-A acknowledged R1 and R2's individual treatment and therapy plans were missing required content noted above.<br><br>No further information is available.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |

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

Type: Full
Date: *07/11/22*
Time: 10:30:00
Report: 1005221064

# Food and Beverage Establishment Inspection Report



**Location:**
Amy Johnson Residence
89 Virginia Street
St Paul, MN55102
Ramsey County, 62

**Establishment Info:**
ID #: 0038324
Risk:
Announced Inspection: Yes

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6512243363
ID #:

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

The following orders were issued during this inspection.

**3-300B Protection from Contamination: cross-contamination, eggs**

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

IN THE SUPERIOR 2-DOOR COOLER, RAW SHELL EGGS WERE STORED OVER COOKED SOUP AND CHICKEN. CORRECTED ON SITE.

*Comply By: 07/11/22*

**4-300 Equipment Numbers and Capacities**

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE A REGISTERING THERMOMETER OR TEMPERATURE SENSITIVE STRIPS TO ENSURE THE DISH MACHINE IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE.

*Comply By: 07/18/22*

**4-300 Equipment Numbers and Capacities**

4-302.14 ** Priority 2 **

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

TEST STRIPS FOR QUATERNARY AMMONIUM COULD NOT BE FOUND DURING INSPECTION. COOK STATES THAT MAINTENANCE PERSONNEL HAS THEM, BUT ADDITIONAL STRIPS WILL BE PURCHASED IN CASE THEY CANNOT BE LOCATED.

*Comply By: 07/18/22*

**2-100 Supervision**

2-102.12AMN

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

NO MN CFPM ON SITE, ALTHOUGH COOK IS CURRENTLY TAKING A SERVSAFE COURSE. INFORMATION LEFT ON SITE FOR HOW TO APPLY FOR MN CFPM.

*Comply By: 08/11/22*

**Surface and Equipment Sanitizers**

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Utensil Surface Temp.: = at 175 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Hold/TURKEY
Temperature: 40 Degrees Fahrenheit - Location: SUPERIOR 2-DOOR COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: SUPERIOR 2-DOOR COOLER
Violation Issued: No

Process/Item: Cold Hold/CHICKEN
Temperature: 40 Degrees Fahrenheit - Location: SUPERIOR 2-DOOR COOLER
Violation Issued: No

Process/Item: Cold Hold/POTATO SALAD
Temperature: 40 Degrees Fahrenheit - Location: SUPERIOR 2-DOOR COOLER
Violation Issued: No

Process/Item: Cooking/BEEF STROGANOFF
Temperature: 173 Degrees Fahrenheit - Location: STOVETOP
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 37 Degrees Fahrenheit - Location: TRUE DISPLAY COOLER
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 38 Degrees Fahrenheit - Location: GE FRIDGE
Violation Issued: No

Process/Item: Cold Hold/AMBIENT
Temperature: 38 Degrees Fahrenheit - Location: FRIGIDAIRE PRODUCE COOLER
Violation Issued: No

Type: Full
Date: *07/11/22*
Time: 10:30:00
Report: 1005221064
Amy Johnson Residence

# Food and Beverage Establishment Inspection Report

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

INSPECTION COMPLETED WITH KITCHEN COOK. DISCUSSED ALL ORDERS WITH HER, AND WITH HRD NURSE EVALUATOR, BENARD NYANGENA.

THIS KITCHEN HAS TREATED WOOD CABINETS AND LAMINATE COUNTERTOPS, ALTHOUGH STAINLESS STEEL PREP SURFACES ARE ALSO PRESENT. CABINETS AND COUNTERS ARE IN GOOD REPAIR AND WILL BE MONITORED AT FUTURE INSPECTIONS.

**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 1005221064 of 07/11/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

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

Signed:_____
LEAH ABBAS
COOK

Signed:_____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us