Electronically delivered

May 19, 2022

Administrator
Blaine White Pine II
12402 Jamestown Street Northeast
Blaine, MN 55449

RE: Project Number(s) SL31675015

Dear Administrator:

On May 9, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 2, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 2, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 2, 2022, found not corrected at the time of the May 9, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on May 9, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

authorized in §144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

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.

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-247-0268.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31675	A. BUILDING: _____ B. WING _____	R 05/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL31675015-1 On May 9, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 2, 2022. At the time of the survey, there were 38 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{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. 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.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed	{0 480}		
{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;	{0 680}		

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{0 680}	Continued From page 2 and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency disaster preparedness plan with all the required content. This had the potential to affect all 38 residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On May 9, 2022, at approximately 3:00 p.m., the surveyor requested to view the licensee's emergency disaster preparedness plan. The licensee's emergency disaster preparedness	{0 680}		

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{0 680}	Continued From page 3 plan lacked evidence of the following required content: - subsistence needs for staff and residents during emergency - policies and procedures for medical documentation - emergency preparedness (EP) training program (including documentation of training provided) - EP testing/annual testing requirements - EP program patient population - development of EP policies and procedures - procedures for tracking of staff and patients - policies and procedures for volunteers - roles under a waiver declared by secretary - primary/alternate means for communication - methods for sharing information - sharing information on occupancy/needs - LTC family notifications On May 9, 2022, at approximately 3:20 p.m., licensed assisted living director (LALD)-B, house manager (HM)-C and LALD-H acknowledged the licensee's emergency disaster preparedness plan provided lacked content as noted above. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated July 22, 2021, indicated the licensee's emergency plan will include all required elements of appendix Z. No further information was provided.	{0 680}		
{0 800} SS=E	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	{0 800}		

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{0 800}	Continued From page 4 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: No further action needed	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	{0 810}		

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{0 810}	Continued From page 5 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action needed	{0 810}		
{01890} SS=D	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 discard expired medication and failed to keep the original prescription label with legible information for one of three residents (R2) with medication storage reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	{01890}		

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{01890}	Continued From page 6 On March 9, 2022, at 2:36 p.m., the surveyor observed the medication storage area for R2. The following was observed and confirmed with registered nurse (RN)-A: - expired medication: epinephrine injection usp auto injector 0.3 milligram (mg) expired March 19, 2022. - missing original prescription label: Symbicort 80/4.5 microgram (mcg) inhale two puffs orally twice daily R2's service plan dated February 12, 2021, indicated R2 received services to include medication administration. On May 9, 2022, at approximately 2:48 p.m., RN-A acknowledged the medication cart had expired medication and medication missing the original prescription label. RN-A stated the missing label had fallen off and should be replaced immediately. The licensee's Medication Management Services policy dated August 1, 2021, lacked verbiage for expired medications and prescription labels. No further information provided.	{01890}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the	{02040}		

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{02040}	Continued From page 7 assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No further action needed	{02040}		

Electronically Delivered

March 22, 2022

Administrator
Blaine White Pine II
12402 Jamestown Street Northeast
Blaine, MN 55449

RE: Project Number(s) SL31675015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 2, 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 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

Sincerely,

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

HHH

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSSITED LIVING PROVIDER LICENSING CORRECTION ORDER 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: Project # SL31675015 On February 28, 2022, through March 2, 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 38 residents receiving services under the provider's Assisted Living with Dementia Care license. The immediate correction order tag identification 2310, identified on March 2, 2022 has been corrected as of March 4, 2022. No further action required.	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. 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 28, 2022, at approximately 9:30 a.m., LALD-B identified self as LALD for the licensee. LALD-B obtained an assisted living director license on July 29, 2021. On February 28, 2022, at approximately 10:30 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-B held a current assisted living director license but not listed as Director of Record for the licensee. On February 28, 2022, at approximately 10:35	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31675	A. BUILDING: _____ B. WING _____	03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

(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
0 110	Continued From page 2 a.m., LALD-B acknowledged they were not listed as the Director of Record for licensee and would contact BELTSS for correction. The licensee's Assisted Living Director policy, dated August 1, 2021, lacked the requirement of the LALD to be registered with BELTSS as the Director of Record for the facility. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days Corrected February 28, 2022	0 110		
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;	0 250		

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0 250	Continued From page 3 (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations, and responsible for the resident's assisted living services, understood all of the assisted living facility with dementia care regulations. This has the potential to affect all	0 250		

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0 250	Continued From page 4 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 28, 2022, at approximately 9:30 a.m., licensed assisted living director (LALD)-B confirmed she was responsible for and participated in the day-to-day operations. LALD-B stated she was familiar with the Assisted Living with Dementia Care licensing rules. The licensee had attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the following orders were issued: Refer to licensing order at Statute 144G.10 Subd. 1a. The licensee failed to ensure the assisted living director was listed as the director of record for licensee. Refer to licensing order at Statute 144G.40, Subd 2. The licensee failed to provide a Uniform Checklist Disclosure of Services (UDALSA) to all residents. Refer to licensing order at Statute 144G.41, Subd 1. The licensee failed to comply with Minnesota	0 250		

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0 250	Continued From page 5 Food Code, chapter 4626. Refer to licensing order at Statute 144G.41 Subd. 1. (13) (i) (A & C). The licensee failed to provide the menu to residents at least a week in advance. Refer to licensing order at Statute 144G.42, Subd. 6. (b). The licensee failed to ensure an individual abuse prevention plan was developed to include statements of the specific measures to be taken to minimize the risk of abuse. Refer to licensing order at Statute 144G.42 Subd. 8. The licensee failed to include in employee record annual training to include principles of person-centered planning/service delivery, Tuberculosis (TB) history and symptom screening, baseline screening, TB training, and annual performance reviews. Refer to licensing order at Statute 144G.42, Subd 10. The licensee failed to develop all requirements for disaster planning and emergency preparedness plan. Refer to licensing order at Statute 144G.45 Subd. 2 (a) (4). The licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. Refer to licensing order at Statute 144G.45 Subd. 2 (b-f). The licensee failed to provide all required content on the fire safety and evacuation plan, evacuation drills, and the minimum required training of staff and residents on fire safety and evacuation. Refer to licensing order at Statute 144G.50, Subd 1. The licensee failed to develop, implement, and provide a contract containing all required content	0 250		

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0 250	Continued From page 6 to all residents. Refer to licensing order at Statute 144G.50 Subd. 2. (a-b) (1-4). The licensee failed to execute a written contract with the required content. Refer to licensing order at Statute 144G.50, Subd 3. The licensee failed to ensure all residents were provided the opportunity to designate a representative, as required. Refer to licensing order at Statute 144.50 Subd. 5. The licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. Refer to licensing order at Statute 144G.63 Subd. 4. The licensee failed to ensure required dementia care training was completed for licensee's employees. Refer to licensing order at Statute 144G.70, Subd 2. The licensee failed to ensure the RN completed assessments of all residents at the frequency required. Refer to licensing order at Statute 144G.70 Subd. 4. (f). The licensee failed to ensure the service plan included the required content. Refer to licensing order at Statute 144G.71, Subd 5. The licensee failed to ensure each resident receiving medication management services had an individualized medication management plan containing all required content. Refer to licensing order at Statute 144G.71 Subd. 20. The licensee failed to discard expired medication in addition licensee failed to keep the	0 250		

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0 250	Continued From page 7 original prescription label with legible information. Refer to licensing order at Statute 144G.81 Subdivision 1. The licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigations on and around the property. Refer to licensing order at Statute 144G.82 Subd. 3. The licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives at the time of move-in. Refer to licensing order at Statute 144G.90, Subd 1. The licensee failed to provide the current Assisted Living Bill of Rights to all residents, in addition the licensee failed to provide the process for filing a complaint. Refer to licensing order at Statute 144G.91, Subd 4. The licensee failed to ensure a side rail was assessed for appropriateness and safety. Twenty-three (23) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules was limited or not evident for compliance with sections 144G.08 to 144G.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 8 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for two of three residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 430		

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0 430	Continued From page 9 The findings include: R1's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life), traumatic brain injury and diabetes mellitus. R1's service plan, dated December 23, 2019, indicated R1 received services to include medication administration, assistance with exercise, bathing assistance, dressing and grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, mobility assistance, escorts, and toileting assistance. R1's record lacked a uniform disclosure of assisted living services and amenities (UDALSA) checklist to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. R2's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life), hypokalemia (a low level of potassium in the bloodstream), depression (persistent sadness and a lack of interest or pleasure in previously enjoyable activities), and obesity (excessive fat accumulation). R2's service plan, dated February 12, 2021, indicated R2 received services to include	0 430		

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0 430	Continued From page 10 medication administration, bathing assistance, feeding assistance, dressing and grooming, oral care, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R2's record lacked a UDALSA checklist to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On March 2, 2022, at approximately 3:40 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B and housing manger (HM)-C acknowledged R1 and R2 did not receive a written checklist listing all services provided under the licensee's assisted living with dementia care license, and the services not provided under the license. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy was requested but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 11 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all 38 current residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: Please refer to the additional documentation included in the Food and Beverage Establishment	0 480		

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0 480	Continued From page 12 Inspection Reports, dated February 28, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all the 38 residents of the facility. This practice resulted in a level one violation (a	0 485		

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0 485	Continued From page 13 violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 28, 2022, at approximately 10:45 a.m., the surveyor observed a menu plan posted on board near to main entrance. The menu posted was not displayed at least one week in advance. On February 28, 2022, at approximately 11:00 a.m., house manager (HM)-C acknowledged the menu plan posted was only for the current week. The licensee's Food Service & Menu Planning policy, dated August 1, 2021, indicated menus would be prepared at least one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630		

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0 630	Continued From page 14 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include statements of the specific measures to be taken to minimize the risk of abuse for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life), traumatic brain injury and diabetes mellitus. R1's service plan, dated December 23, 2019, indicated R1 received services to include medication administration, assistance with exercise, bathing assistance, dressing and grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, mobility assistance, escorts, and toileting	0 630		

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0 630	Continued From page 15 assistance. R1's Vulnerability Assessment and Prevention Plan, dated May 3, 2021, included the following vulnerabilities: cognition, anxiety and agitation, lack of interest, physical decline, limited range of motion, decreased endurance, and unable to manage finances. R1's plan failed to include statements of the specific measures to be taken to minimize the risk of abuse. R2's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life), hypokalemia (a low level of potassium in the bloodstream), depression (persistent sadness and a lack of interest or pleasure in previously enjoyable activities), and obesity (excessive fat accumulation). R2's service plan, dated February 12, 2021, indicated R2 received services to include medication administration, bathing assistance, feeding assistance, dressing and grooming, oral care, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R2's Vulnerability Assessment and Prevention Plan, dated January 14, 2022, included the following vulnerabilities: poor cognition, anxiety/depression, lack of interest, physical decline, limited range of motion, decreased endurance, and unable to manage finances. R2's plan failed to include statements of the specific measures to be taken to minimize the risk of abuse. R3's diagnoses included dementia (a group of	0 630		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

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0 630	Continued From page 16 symptoms that affects memory, thinking and interferes with daily life) without behavioral disturbance, type two diabetes, and disorientation. R3's service plan, dated November 5, 2021, indicated R2 received services to include medication administration, diabetic management, bathing assistance, behavioral intervention, feeding assistance, dressing and grooming, oral care, blood glucose monitoring, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R3's Vulnerability Assessment and Prevention Plan, dated November 1, 2021, included the following vulnerabilities: poor cognition, anxiety/depression, lack of interest, physical decline, limited range of motion, decreased endurance, chronic pain, poor vision, forgetfulness, verbally abusive, physical aggression, inappropriate sexual behavior and unable to manage finances. R3's plan failed to include statements of the specific measures to be taken to minimize the risk of abuse. On March 2, 2022, at approximately 4:20 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B, and house manager (HM)-C acknowledged R1, R2 and R3's Vulnerability Assessment and Prevention Plans lacked statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated August 1, 2021, indicated the licensee will develop	0 630		

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0 630	Continued From page 17 measures to minimize maltreatment based on resident identified information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation,	0 650		

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0 650	Continued From page 18 employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee record included all required content for one of two employees (registered nurse (RN)-E) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-E started employment on May 6, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-E's employee record lacked annual training to include principles of person-centered planning/service delivery, Tuberculosis (TB) history and symptom screening, baseline screening, TB training, and annual performance reviews. On March 2, 2022, at approximately 11:45 a.m., registered nurse (RN)-A and licensed assisted living director (LALD)-B acknowledged RN-E's employee record lacked the required content and stated all these requirements were met except they could not find them.	0 650		

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0 650	Continued From page 19 The licensee's employee records policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 20 by: Based on observation, interview, and record review the licensee failed to have a written emergency disaster preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all three residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On February 21, 2022, at approximately 10:10 a.m., the surveyor did not observe a posting of an emergency disaster plan during the facility tour. On February 22, 2022, at approximately 11:00 a.m., the surveyor requested to view the licensee's emergency disaster preparedness plan. The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - hazard vulnerability assessment - a comprehensive program to include pandemics - subsistence needs for staff and residents during emergency - a communication plan that included names and contact information for physicians	0 680		

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0 680	Continued From page 21 - Policies and procedures for medical documentation - emergency preparedness (EP) training program (including documentation of training provided) - EP testing/annual testing requirements - EP Program Patient Population - Process for EP Collaboration - Development of EP Policies and Procedures - Procedures for Tracking of Staff and Patients - Policies and Procedures Including Evacuation - Policies and Procedures for Sheltering - Policies and Procedures for Volunteers - Roles under a Waiver Declared by Secretary - Development of Communication Plan - Names and Contact Information - Emergency Officials Contact Information - Primary/Alternate Means for Communication - Methods for Sharing Information - Sharing Information on Occupancy/Needs - LTC Family Notifications On March 2, 2022, at approximately 4:20 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B, and house manager (HM)-C acknowledged the licensee's emergency disaster preparedness plan provided lacked content as noted above. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy, dated July 22, 2021, indicated the licensee's emergency plan will include all required elements of appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 800	Continued From page 22	0 800		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: On March 2, 2022, between 9:45 a.m. and 12:45 p.m., survey staff toured the facility with the maintenance assistant (M)-F, and the following findings were observed by survey staff: -The three sets of smoke compartment doors next to resident rooms #10, #28, and #29 were	0 800		

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0 800	Continued From page 23	0 800		

not properly working. The sets of doors when released failed to meet the door stops necessary to provide smoke compartment protection. During the tour, the M-F had asked an employee to work on adjusting the hardware of the doors immediately upon the findings.

-The hardware for the set of double doors for the supply storage closet on the second floor was damaged where the lock secured on the set of doors failed to prevent the doors from being opened by survey staff by pulling on the door handle. This posed a chemical safety concern for resident access where containers of sodium chloride, bottles of sanitizers, and other supplies were stored.

-Damped dirty rags were located under the kitchenette sink on the second floor that needed to be discarded and the cabinet under the sink needed to be cleaned. Employee M-F explained that there was a recent clog in the pipe and repairs were made.

-The integral backflow preventer on the faucet of the service (mop) sink located inside the first-floor mechanical room was damaged and comprised. In addition, a "Y" fitting was improperly hooked up to the same mop sink threaded faucet to serve multiple chemical soap dispensers. Survey staff explained to the M-F that the installation was not in compliance with code to prevent cross-connection of chemicals to the building water supply system and should be consulted with a local authorized contractor to repair and for code-compliant installation since a "Y" fitting connection on the faucet does not allow for the pressure bleeding device installation.

-The installation of the chemical soap dispenser

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0 800	Continued From page 24 connected to the faucet of the mop sink located inside the commercial kitchen on the first floor lacked a pressure bleeding device to prevent cross-connection of the building water supply and should be consulted with a local authorized contractor for code-compliant installation. On March 2, 2022, at approximately 1:45 p.m., the licensed assisted living director (LALD)-B and the House Manager (HM)-C acknowledged the above findings during the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be	0 810		

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0 810	Continued From page 25 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, evacuation drills, and the minimum required training of staff and residents on fire safety and evacuation. This has the potential to directly affect the safety of staff and all residents receiving care. 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 March 2, 2022, at approximately 12:45 pm, survey staff received the facility fire safety and evacuation plan and related documentation for review:	0 810		

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0 810	Continued From page 26 FIRE SAFETY AND EVACUATION PLAN -The building layout plan lacked the identification of sleeping locations and the number of sleeping rooms. Furthermore, the building layout plan was not legible. -The policy documentation lacked the specific fire protection procedures necessary for addressing all residents including any unique resident-specific situations including memory care residents during an evacuation as well as a relocation of the resident plan for a full evacuation. -The documentation lacked fire protection procedures for the residents. TRAINING -The policy documentation lacked the content of employee training on the fire safety and evacuation plan upon hire and at least twice per year thereafter. -The policy documentation lacked the content of resident training for residents who are capable of assisting in their own evacuation on proper actions to take during a fire event to include movement, evacuation, or relocation. The training must be available to residents at least once a year. FIRE and EVACUATION DRILLS The policy documentation and records showed sufficient employee fire safety drills performed to date but lacked details of evacuation drills. Drills must also include evacuation drills at least twice per year per shift, with at least one evacuation drill every other month. Fire drills and evacuation drills may be combined when conducting drills. On March 2, 2022, at approximately 2:00 p.m., the licensed assisted living director (LALD)-B and	0 810		

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0 810	Continued From page 27 the House Manager (HM)-C acknowledged the above findings during the exit interview. Survey staff explained that all records of training and evacuation drills must be kept to show the minimum frequencies to substantiate requirements have been met. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (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. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.	0 900		

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0 900	Continued From page 28 (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. (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of three residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R1 started receiving services October 1, 2018, under the comprehensive license and transitioned to receive services under the assisted living license with dementia care August 1, 2021. R1's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life), traumatic brain injury and diabetes mellitus.	0 900		

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0 900	Continued From page 29 R1's service plan, dated December 23, 2019, indicated R1 received services to include medication administration, assistance with exercise, bathing assistance, dressing and grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, mobility assistance, escorts, and toileting assistance. R1's record lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (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. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (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. (f) The resident must agree in writing to any additions or amendments to the contract. Upon	0 900		

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	31675	A. BUILDING: _____ B. WING _____	03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

(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
0 900	Continued From page 30 agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. R2 started receiving services October 12, 2020, under the comprehensive license and transitioned to receive services under the assisted living license with dementia care August 1, 2021. R2's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life). R2's service plan, dated February 12, 2021, indicated R2 received services to include medication administration, bathing assistance, feeding assistance, dressing and grooming, oral care, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R2's record lacked a written contract with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed	0 900		

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0 900	Continued From page 31 contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (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. (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. On March 2, 2022, at approximately 4:20 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B, and house manager (HM)-C acknowledged the licensee did not execute a written contract with R1 and R2. In addition the LALD stated all residents excute a contract with licensee on admission, but licensee will review resident records to ensure no resident missed to sign their contract. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, indicated the licensee will receive a signed contract when a prospective resident moves in. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 910 SS=F	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous	0 910		

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0 910	Continued From page 32 place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of three residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at 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: R3's diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life) without behavioral disturbance, type two diabetes, and disorientation. R3's service plan, dated November 5, 2021, indicated R2 received services to include medication administration, diabetic management,	0 910		

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0 910	Continued From page 33 bathing assistance, behavioral intervention, feeding assistance, dressing and grooming, oral care, blood glucose monitoring, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R3's contract, dated November 3, 2022, lacked the license number of the facility. On March 2, 2022, at approximately 4:15 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B, and house manager (HM)-C acknowledged R3's contract lacked required content. RN-A, LALD-B, and HM-C also stated this could be true for all other residents. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, indicated the licensee will receive a signed contract when a prospective resident moves in but lacked the verbiage for required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE	0 950		

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0 950	Continued From page 34 FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for one of three residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 950		

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0 950	Continued From page 35 The findings include: R3's diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life) without behavioral disturbance, type two diabetes, and disorientation. R3's service plan, dated November 5, 2021, indicated R2 received services to include medication administration, diabetic management, bathing assistance, behavioral intervention, feeding assistance, dressing and grooming, oral care, blood glucose monitoring, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R3's contract, dated November 3, 2022, included an acknowledgement page indicating R3 had received the designation representative form but there was no assigned representative neither was there a verbatim notice on a separate document from the contract "right to designate a representative for certain purposes". On March 2, 2022, at approximately 4:15 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B and house manager (HM)-C acknowledged R3's contract lacked a designated representative for the resident. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, indicated the licensee will receive a signed contract when a prospective resident moves in but lacked the verbiage for designating a representative. No further information was provided.	0 950		

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0 950	Continued From page 36 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the 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), 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 March 1, 2022, at approximately 12:20 p.m., R3's contract was requested.	0 970		

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0 970	Continued From page 37 R3's assisted living contract included three clauses that indicated R3 would waive the licensee's liability for health, safety, or personal property of a resident. Page 13-14 section 25 (Miscellaneous Provisions) sub-divisions A, B and C of the contract indicated a resident assumes all risks associated with occupancy. The resident will hold harmless the provider, its employees, and agents from and against any loss, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. On March 2, 2022, at approximately 4:15 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B, and house manager (HM)-C acknowledged the contract required residents to waive the licensee's liability for health, safety, or personal property. The licensee's Signing an Assisted Living Contract policy, dated August 1, 2021, indicated the licensee will receive a signed contract when a prospective resident moves in but lacked to address required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section	01490		

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01490	Continued From page 38 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care training was completed for two of three employees (licensed assisted living director (LALD)-B, registered nurse (RN)-E) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: LALD-B started employment on January 21, 2010, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-E started employment on May 6, 2019, under the comprehensive home care license and began providing assisted living services on August 1, 2021. LALD-B's and RN-E's employee records lacked evidence of at least eight hours of initial dementia training within 120 and 80 working hours respectively of the employment start date to include: (1) an explanation of Alzheimer's disease and other dementias;	01490		

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01490	Continued From page 39 (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. On March 2, 2022, at approximately 4:10 p.m., RN-A, LALD-B and house manager (HM)-C acknowledged the employees' records were missing the required dementia care training. They also stated the RNs completed only four hours of dementia training at hire and thereafter two hours annually. The licensee's Dementia Training policy, dated August 1, 2021, indicated the missing dementia training topics above should be completed within 80 hours of employment start date for the RN and 120 hours of employment start date for the LALD. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01490		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620		

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01620	Continued From page 40	01620		

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

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days as required for one of three residents (R2) with records reviewed.

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

The findings include:

R2 started services on November 5, 2021.

R2's diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life) without behavioral disturbance, type two diabetes, and

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01620	Continued From page 41 disorientation. R2's service plan, dated November 5, 2021, indicated R2 received services to include medication administration, diabetic management, bathing assistance, behavioral intervention, feeding assistance, dressing and grooming, oral care, blood glucose monitoring, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R2's record included 90-day assessments completed on September 2, 2021, and December 6, 2021. On March 2, 2022, at approximately 12:10 p.m., RN-A acknowledged R2's 90-day assessments exceeded 90 days from previous assessment. The licensee's Assessments, Reviews & Monitoring policy, dated August 1, 2021, read 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 last date of the review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each	01650		

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01650	Continued From page 42 service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01650		

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01650	Continued From page 43 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's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life), traumatic brain injury and diabetes mellitus. R1's service plan, dated December 23, 2019, indicated R1 received services to include medication administration, assistance with exercise, bathing assistance, dressing and grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, mobility assistance, escorts, and toileting assistance. R1's service plan lacked the content to include: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R2's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life), hypokalemia (a low level of potassium in the bloodstream), depression (persistent sadness and a lack of interest or pleasure in previously enjoyable activities), and obesity (excessive fat accumulation).	01650		

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BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

(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
01650	Continued From page 44 R2's service plan, dated February 12, 2021, indicated R2 received services to include medication administration, bathing assistance, feeding assistance, dressing and grooming, oral care, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R2's service plan lacked the content to include: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. R3's diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life) without behavioral disturbance, type two diabetes, and disorientation. R3's service plan, dated November 5, 2021, indicated R2 received services to include medication administration, diabetic management, bathing assistance, behavioral intervention, feeding assistance, dressing and grooming, oral care, blood glucose monitoring, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R3's service plan lacked the content to include: - the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse	01650		

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01650	Continued From page 45 change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On March 2, 2022, at approximately 4:10 p.m., RN-A, licensed assisted living director (LALD)-B, and house manager (HM)-C acknowledged the residents' service plans were missing required content and further stated all of the licensee's residents will be missing the same content. The licensee's Service Plan policy, dated August 1, 2021, indicated a service plan will include all the missing content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided;	01730		

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01730	Continued From page 46 (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management record with the required content and failed to complete annual reassessment for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a	01730		

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01730	Continued From page 47	01730		

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:

R1
On March 1, 2022, at approximately 8:30 a.m., ULP-D administered morning medications to R1.

R1's service plan, dated December 23, 2019, indicated R1 received services to include medication administration, assistance with exercise, bathing assistance, dressing and grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, mobility assistance, escorts, and toileting assistance.

R1's Physician Order Sheet, signed and dated February 22, 2022, indicated R1 received:
- acetaminophen 500 milligram (mg) tablet take two tablets three times daily orally
- cyclobenzaprine tablet 5 mg take one tablet by mouth daily
- divalproex 250 mg tablet take two tablets by mouth at bedtime
- Lantus solos injection 100 per milliliter every morning 20 units subcutaneously
- metformin hcl 500 mg tablet take one tablet by mouth twice daily
- doxylamine succinate 25 milligram tablet taken one tablet orally at bedtime as needed

R1's medication administration record (MAR),

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01730	Continued From page 48 dated February 2022, indicated on February 28, 2022, at approximately 9:00 a.m., R1 received: - acetaminophen 500 mg two tablets orally - aripiprazole 20 mg tablet orally - fluconazole 200 mg tablet orally - Lantus solos injection 100 per ml inject 20 units - metformin hcl 500 mg tablet orally - blood glucose check reading was 148 R2 R2's service plan, dated February 12, 2021, indicated R2 received services to include medication administration, bathing assistance, feeding assistance, dressing and grooming, oral care, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R2's Physician Order Sheet, signed and dated February 22, 2022, indicated R2 received: - donepezil 10 mg tablet at bedtime - Lexapro 10 mg tablet daily - levothyroxine 100 mg tablet daily before breakfast - melatonin 5 mg tablet every evening - metoprolol tar 25 mg tablet two times daily - quetiapine 25 mg tablet at bedtime R3 R3's service plan, dated November 5, 2021, indicated R2 received services to include medication administration, diabetic management, bathing assistance, behavioral intervention, feeding assistance, dressing and grooming, oral care, blood glucose monitoring, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry.	01730		

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01730	Continued From page 49 R3's Physician Order Sheet, signed and dated February 15, 2022, indicated R2 received: - atropine 2.5/0.025 mg tablet three times daily - Eliquis 5 mg tablet two times daily - glipizide 10 mg tablet two times daily - levetiracetam 1000 mg tablet two times daily - metformin 1000 mg tablet two times daily - metoprolol 50 mg tablet two times daily - valsartan 160 mg tablet daily - sertraline 50 mg tablet daily R1, R2, and R3's record lacked an individual medication management plan to include: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On March 2, 2022, at approximately 3:40 p.m.,	01730		

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01730	Continued From page 50 registered nurse (RN)-A acknowledged the resident records were missing an individual medication management plan. RN-A also stated the licensee updated the nursing assessment template to include the individual medication management plan in the future. The licensee's Medication Management - Assessment, Monitoring & Reassessment policy, dated August 1, 2021, lacked the verbiage to include required content of an individual medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	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 discard expired medication and failed to keep the original prescription label with legible information for one of three residents (R2) with medication storage reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890		

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01890	Continued From page 51	01890		

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

The findings include:

On March 1, 2022, at approximately 8:10 a.m., ULP-D administered morning medications to R2.

On March 1, 2022, at 9:36 a.m., the surveyor observed the medication storage area for R2. The following was observed and confirmed with registered nurse (RN)-A:
- Expired medication: Calamine lotion 8-8% zinc oxide topical with expiration date January 11, 2019 and Aquaphor original ointment with expiration date November 17, 2021.
- Missing original prescription label: Aquaphor original ointment, Ketorolac tromethamine ophthalmic solution, Prednisolone acetate ophthalmic suspension, and Adapt paste.

R2's service plan, dated February 12, 2021, indicated R2 received services to include medication administration.

On March 1, 2022, at approximately 9:40 a.m., RN-A acknowledged the medication cart had some expired medications and some medications missing original prescription labels.

The licensee's Medication Management Services policy, dated August 1, 2021, lacked verbiage for expired medications and prescription labels.

No further information provided.

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01890	Continued From page 52 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide a complete facility hazard vulnerability or safety risk assessment (HVA) plan to identify hazard vulnerabilities and mitigations on and around the property. The hazards identified on the HVA plan must be mitigated to protect the residents from harm. This has the potential to directly affect all memory care residents receiving assisted living services. 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 a widespread scope (when	02040		

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02040	Continued From page 53 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: On March 2, 2022, between 9:45 a.m. and 12:45 p.m., survey staff toured the facility with the maintenance assistant (M)-F. On March 2, 2022, at approximately 12:45 pm, survey staff received the HVA documentation for review, and the following were observed: -The HVA plan lacked specific hazard assessment content on and around the property to protect the dementia care residents from harm. Hazard assessments on the HVA plan must include specific safety risks or potential hazard vulnerabilities such as resident elopement throughout and around the memory care building including deactivation of power doors due to loss of power or fire alarm activation, the potential access by residents to storage closets where chemicals were stored due to failure of door hardwire or doors not secured, the risks of resident room windows being comprised, accessing nearby highways when elopement occurs, and the risks of the misuse of portable fire extinguishers without access restrictions or architectural accessories throughout the building. - The HVA plan lacked mitigations documentation including safety measures and/or training provided to the safety risk assessment (vulnerabilities) identified on and around the property to protect all memory care residents from harm. On March 2, 2022, at approximately 2:00 p.m., the licensed assisted living director (LALD-B) and	02040		

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02040	Continued From page 54 the House Manager (HM)-C acknowledged the above findings during the exit interview. Survey staff explained that all potential safety risks or harm on and around the property must be identified, assessed, and mitigated in the HVA plan documentation and implemented to protect memory care residents from harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented;	02110		

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02110	Continued From page 55 (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives at the time of move-in for three of three residents (R1, R2, R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 started receiving services October 1, 2018, under the comprehensive license and transitioned to receive services under the assisted living license with dementia care August 1, 2021. R1's diagnoses included unspecified dementia (a	02110		

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02110	Continued From page 56 group of symptoms that affects memory, thinking and interferes with daily life), traumatic brain injury and diabetes mellitus. R1's service plan, dated December 23, 2019, indicated R1 received services to include medication administration, assistance with exercise, bathing assistance, dressing and grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, mobility assistance, escorts, and toileting assistance. R1's record lacked evidence to have received required policies and procedures for assisted living with dementia care. R2 started receiving services October 12, 2020, under the comprehensive license and transitioned to receive services under the assisted living license with dementia care August 1, 2021. R2's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life). R2's service plan, dated February 12, 2021, indicated R2 received services to include medication administration, bathing assistance, feeding assistance, dressing and grooming, oral care, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R2's record lacked evidence to have received required policies and procedures for assisted living with dementia care. R3 started receiving services November 5, 2021.	02110		

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02110	Continued From page 57 R3's diagnoses included dementia (a group of symptoms that affects memory, thinking and interferes with daily life) without behavioral disturbance and disorientation. R3's service plan, dated November 5, 2021, indicated R3 received services to include medication administration, diabetic management, bathing assistance, behavioral intervention, feeding assistance, dressing and grooming, oral care, blood glucose monitoring, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R3's record lacked evidence to have received required policies and procedures for assisted living with dementia care. On March 2, 2022, at approximately 3:50 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B, and house manager (HM)-C acknowledged the licensee's residents and the residents' legal and designated representatives did not receive the required dementia care policies. The licensee's Assisted Living with Dementia Care Required policy, dated August 1, 2021, indicated the licensee will provide the residents and residents' designated representatives the required policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	02110		

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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
02240	Continued From page 58	02240		
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31675	A. BUILDING: _____ B. WING _____	03/02/2022

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BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

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02240	Continued From page 59 because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights (BOR) for Assisted Living Residents was provided to the residents and a written acknowledgement received; in addition the licensee failed to provide the process for filing a complaint for two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee transitioned from a Comprehensive Home Care license to an Assisted Living license with dementia care on August 1, 2021. R1's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life), traumatic brain injury and diabetes mellitus. R1's service plan, dated December 23, 2019,	02240		

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	31675	A. BUILDING: _____ B. WING _____	03/02/2022

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02240	Continued From page 60 indicated R1 received services to include medication administration, assistance with exercise, bathing assistance, dressing and grooming, blood glucose monitoring, nurse assessments, weekly housekeeping, laundry, mobility assistance, escorts, and toileting assistance. R1's record included an acknowledgement for a copy of the home care BOR form, dated December 23, 2019, R2's diagnoses included unspecified dementia (a group of symptoms that affects memory, thinking and interferes with daily life). R2's service plan, dated February 12, 2021, indicated R2 received services to include medication administration, bathing assistance, feeding assistance, dressing and grooming, oral care, nursing assessment, reassurance checks, vital signs including weight, weekly housekeeping, transfer assistance with one person, escorts, toileting assistance and laundry. R2's Acknowledgements form, dated and initialed by R2's daughter on October 27, 2020, indicated they received the home care BOR and a written complaint procedure. On March 2, 2022, at approximately 4:15 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B and house manager (HM)-C acknowledged the residents did not receive the current Minnesota BOR for Assisted Living Residents and lacked information or processes for filing a complaint. The licensee's policy for BOR and a written complain procedure was requested but not	02240		

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02240	Continued From page 61 provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for three of three residents (R2, R5, and R6) who utilized bed rails. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 On March 2, 2022, at approximately 9:30 a.m., the surveyor observed R2's bilateral bed side rails.The rails were approximately three feet wide	02310		

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	31675	A. BUILDING: _____ B. WING _____	03/02/2022

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02310	Continued From page 62	02310		

by one and one-half feet in height. The rail mid section had four vertical bars (about 1 1/2 feet in height) and were flanked by two additional vertical bars each side, which were about one foot in height. There were eight vertical bars in total, each spaced about four inches apart. The bilateral bed rails were loose and easily movable.

R2's diagnoses included unspecified dementia, unspecified depression, and obesity.

R2's Side Rail Use Assessment Form, dated February 28, 2022, indicated the registered nurse (RN) had completed bed rail safety and education for R2 and R2's family.

R2's Vulnerability, Safety & Risk Assessment, dated January 14, 2022, indicated R2 was not able to give accurate information due to advanced dementia; was able to ambulate and use a wheel chair for long distance; and R2 has poor endurance and strength. The assessment lacked any mention R2 had or used bed side rails.

R5
On March 2, 2022, at approximately 10:20 a.m., he surveyor observed R5's bilateral bed side rails. The rails were approximately three feet wide by one and one-half feet in height. The rails mid section had four vertical bars (about 1 1/2 feet in height) and were flanked by two additional vertical bars each side, which were about one foot in height. There were eight vertical bars in total, each spaced about four inches apart. The bed rail was loose and easily movable.

R5's diagnoses included dementia without behavioral disturbance, anxiety disorder, Parkinson's disease, and major depressive

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	31675	A. BUILDING: _____ B. WING _____	03/02/2022

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BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

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02310	Continued From page 63 disorder. R5's Side Rail Use Assessment Form, dated February 28, 2022, indicated the RN had completed bed rail safety and education for R5 and R5's family. R5's Vulnerability, Safety & Risk Assessment, dated November 4, 2021, indicated R5 was not able to give accurate information due to short term memory; was not able to ambulate and used a wheel chair with help from staff; and R5 has poor endurance and strength. The assessment lacked any mention R5 had or used bed side rails. R6 On March 2, 2022, at approximately 10:30 a.m., the surveyor observed R6's bed side rail. The bed rail was approximately three feet wide by one and one-half feet in height. The rail mid section had four vertical bars (about 1 1/2 feet in height) and were flanked by two additional vertical bars each side, which were about one foot in height. There were eight vertical bars in total, each spaced about four inches apart. The bed rail was loose and easily movable. R6's diagnoses included dementia, Parkinson's disease, and hypokalemia (low potassium in the bloodstream). R6's Side Rail Use Assessment Form, dated February 28, 2022, indicated the RN had completed bed rail safety and education for R6 and R6's family. R6's Vulnerability, Safety & Risk Assessment, dated October 5, 2021, indicated R6 was confused and forgetful; was not able to ambulate	02310		

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02310	Continued From page 64 safely without staff help; and R6 had poor endurance and strength. The assessment lacked any mention R6 had or used bed side rails. On March 2, 2022, at approximately 11:20 a.m., RN-A and house manager (HM)-C acknowledged the resident bed side rails were easily moveable and stated the licensee will have in place a system to monitor and fasten the screws when loose. The licensee's Side Rails policy, dated August 1, 2021, indicated the licensee will verify the side rail in use is of safe design and utilized consistent with the manufacturer's direction and "be aware of wobbly side rails". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate This immediate correction order identified on March 2, 2022, has been corrected as of March 4, 2022. This was confirmed by the surveyor's on-site observation and approved by evaluation supervisor. No further action required.	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *02/28/22*
Time: 15:22:56
Report: 1018221029

Food and Beverage Establishment Inspection Report

Location:
Blaine White Pine Ii
12402 Jamestown Street Ne
Blaine, MN55449
Anoka County, 02

Establishment Info:
ID #: 0038359
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632054163
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.

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

DELI MEAT AND CHEESE OBSERVED WITHOUT DATE MARK IN THE STAND UP COOLER. COMPLY WITH RULE.

Comply By: 03/01/22

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.

FIRM HAS A THERMOMETER FOR THE DISHWASHER BUT IT WAS NOT FUNCTIONAL AT THE TIME OF INSPECTION. COMPLY WITH RULE.

Comply By: 03/04/22

6-300 Physical Facility Numbers and Capacities

6-301.12 ** Priority 2 **

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO HAND TOWELS AVAILABLE AT EITHER HAND WASHING SINK IN THE KITCHEN AREA. COMPLY WITH RULE.

Comply By: 03/01/22

2-100 Supervision

2-102.12AMN

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

FIRM DOES NOT CURRENTLY HAVE A CERTIFIED FOOD PROTECTION MANAGER. COMPLY WITH RULE.

Comply By: 06/01/22

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

INTERIOR OF ICE MACHINE OBSERVED WITH PINK BUILD-UP. DISCUSSED WITH THE KITCHEN MANAGER TO HAVE THE ICE MACHINE CLEANED AND SANITIZED.

Comply By: 03/04/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT SINK
Violation Issued: No

Hot Water: = at 174 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ PEACHES
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 39 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

VIEWED EMPLOYEE ILLNESS LOG AND DISCUSSED ILLNESS POLICY

INSPECTION CONDUCTED WITH CHRIS FOSTER PRESENT

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 1018221029 of 02/28/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed:_____

AARON HANSON
KITCHEN MANAGER

Inspector Number 1018

6512014500