DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 2, 2023

Licensee
Brookdale Plymouth
15855 22nd Avenue North
Plymouth, MN 55447

RE: Project Number(s) SL30690015

Dear Licensee:

On May 17, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 8, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

Electronically Delivered

April 13, 2023

Licensee
Brookdale Plymouth
15855 22nd Avenue North
Plymouth, MN 55447

RE: Project Number(s) SL30690015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 8, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

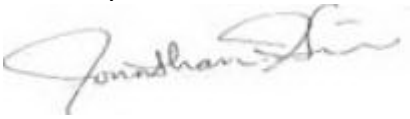
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-281-9796
JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30690	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLYMOUTH	15855 22ND AVENUE NORTH PLYMOUTH, MN 55447

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30690015-0 On March 6, 2023, through March 8, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 43 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care licensed 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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 7, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one employee (unlicensed personnel (ULP)-D) observed to perform blood glucose testing, insulin administration, and application of lidocaine patch. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 7, 2023, at 7:30 a.m., the evaluator observed ULP-D preparing to check R2's blood glucose, administer insulin, and apply lidocaine patch to R2's lower back. ULP-D gathered the supplies from the medication cart for glucose testing, insulin administration, and lidocaine patch application, wheeled R2 from the dining room to her apartment living room, gathered the supplies	0 510		

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0 510	Continued From page 3 from the medication cart for glucose testing, insulin administration. - Without performing hand hygiene, ULP-D: donned gloves, cleansed R2's finger with an alcohol pad, used a lancet to poke the finger, placed a drop of blood onto the testing strip in the device, and informed R2 her blood glucose reading was 222. Then, ULP-D cleansed R2's abdominal area with an alcohol prep pad, administered 21 units of Lantus insulin SQ (subcutaneously) into abdominal area, placed Lantus insulin cap on, opened and applied lidocaine patch to R2's lower back. - ULP-D then removed the soiled gloves. Without performing hand hygiene, ULP-D put the insulin back in the medication cart, discarded the insulin needle in the sharps container, documented services, put the glucometer away in the medication cart, and then performed hand hygiene. On March 7, 2023 at 8:15 a.m., ULP-D stated he was trained by registered nurse (RN)-B. On March 8, 2023, at 10:40 a.m., RN-B stated ULPs had overall training in infection control including handwashing, RN-B stated "we have completed a re-training with all employees, and we complete yearly training." The licensee's Handwashing/Hand Hygiene policy dated October 2021, directed handwashing would be performed by all employees, as necessary, during routine resident care, before applying non-sterile gloves, after contact with medical equipment No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510		

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0 510	Continued From page 4 days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all forty-three residents receiving assisted living services, staff, and visitors.	0 680		

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0 680	Continued From page 5 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 06, 2023, at 12:30 p.m., licensed assisted living director (LALD)-A provided the licensee's incomplete emergency preparedness plan. The licensee's plan lacked the following required content: -EP training and testing program; -EP training program for staff (including documentation of training provided); -annual EP testing requirements. On March 06, 2023, at 2:11 p.m., maintenance manager (MM)-G indicated that the licensee had conducted fire drills, however, MM-G stated, "we had a flood, and I might have lost some papers because my office was where the flood happened." The licensee's Emergency Manual protocol dated 2021, indicated the licensee would be responsible for preparation and planning for potential emergencies in accordance with local, state, and federal regulations. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 6 (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide audible smoke alarms in the resident rooms throughout the facility. This deficient condition had the ability to affect all staff and residents.	0 780		

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0 780	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 8, 2023, at approximately 2:45 p.m. with maintenance manager (MM)-G it was observed that smoke detectors were installed in the resident rooms and connected to the general fire alarm system but there was no audible notification in the resident room. This deficient finding was visually verified by MM-G at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	0 800		

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0 800	Continued From page 8 Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 8, 2023, at approximately 2:30 p.m. with maintenance manager (MM)-G it was observed that ceiling tiles were missing in the storage room near the maintenance office because of a water leak above the ceiling in the common area of the Claire side of the building. Ceilings are required to be maintained as designed and installed. It was also observed that a dryer vent was disconnected from the dryer allowing exhaust to be discharged into the laundry room in the Bridge portion of the building. Dryer vent exhaust is required to be directed to the exterior of the building. A fire-resistant rated door was out of adjustment, delaminating and would not latch closed in the laundry room of the Bridge area of the building. Fire resistant rated doors are required to be maintained as designed and installed and positively latch.	0 800		

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0 800	Continued From page 9 The latch was observed broken and had no handle for operation, on the door leading from the shower room to the laundry room in the Bridge portion of the building. A light switch cover was observed with a gap between the wall and electrical box to allow contact with electrical wires in the community shower room of the F wing. A light switch cover was observed with a gap between the wall and electrical box to allow contact with electrical wires in the common bathroom of the A wing. A door was observed with the screws pulled out of the hinge in the shower room of the F wing leading to the restroom of the E wing. A door handle was observed broken and not operable in the corridor near resident room E5. A door was observed with the screws pulled out of the hinge in the shower room of the E wing leading to the center restroom. The fire-resistant rated door in the laundry room of the D wing was observed with a missing strike plate and the door did not positively latch closed. A bi-fold closet door in resident room D4 was observed out of the track and leaning on the wall. A large portion of ceiling tile and wall base trim were observed missing because of a water leak above the ceiling in the common area of the Claire side of the building. Ceilings are required to be maintained as designed and installed.	0 800		

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0 800	Continued From page 10 At the time of the tour there was no documentation available to verify required maintenance of the fire alarm system. It was observed that all furnace rooms have fire-resistant rated doors that do not positively latch in the exit vestibules in each wing. It was observed that wall base was missing in resident room C3 due to a water leak above the ceiling in the common area of the Claire side of the building. It was observed the door latch in the laundry room is broken and does not release to open in the B-C wing. A ceiling tile was observed missing in the exit vestibule of the B wing. Ceilings are required to be maintained as designed and installed. A large hole in the wall was observed behind the wash machine in the laundry room of the A wing. The fire-resistant walls of the laundry room are required to be maintained as designed and installed. A broken door handle was observed in the laundry room of the A wing. A water line leak which had been dripping on the floor for a long time under the bathroom sink in resident room A7 was observed. Storage was observed in the marked means of egress corridor (referred to as the back hallway by maintenance manager) on the facility tour. Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants and emergency responders during an	0 800		

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0 800	Continued From page 11 emergency. A cleaning chemical container that was damaged, leaking and covering the floor and seeping into the wall was observed in the housekeeping room of the D wing. It was observed that clear door handle guards were installed on remote exit doors to limit residents from inadvertently operating the door handle and activating the wonder guard alarm. The guards have a cut out on the bottom to reach into and operate the handle for exiting. Exterior marked exits are required to be maintained as designed and installed and be fully available for use without obstructions. These deficient conditions were visually verified by MM-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 810		

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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
0 810	Continued From page 12 evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review of available documentation and interview were conducted on March 8, 2023, at	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30690	A. BUILDING: _____ B. WING _____	03/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE PLYMOUTH	15855 22ND AVENUE NORTH PLYMOUTH, MN 55447

(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
0 810	Continued From page 13 approximately 1:30 p.m. of documents provided by maintenance manager (MM)-G on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not have specific employee actions for this facility to be taken in the event of a fire or similar emergency located within the plan. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents located within the plan. Record review of the available documentation indicated that employees did not receive training upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provided training once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. Record review of the available documentation did not indicate that evacuation drills had been conducted twice per year per shift and least once every other month as required. All deficiencies were verified by MM-G during the interview at approximately 2:30 p.m. TIME PERIOD FOR CORRECTION: Twenty-one	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30690	A. BUILDING: _____ B. WING _____	03/08/2023

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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
0 810	Continued From page 14 (21) days.	0 810		
0 950 SS=F	144G.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 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 two of four residents (R2,	0 950		

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	30690	A. BUILDING: _____ B. WING _____	03/08/2023

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0 950	Continued From page 15 R3) the opportunity to identify a designated representative. 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: R2 R2's personal service plan dated February 14, 2023, indicated R2's services included medication administration, dependence for activities of daily living (ADLs), assistance with dressing, grooming, showering, toileting, and escorts. R2's residency agreement dated January 19, 2022, did not contain a notice with the required statutory language for R2 to identify a designated representative or documentation that R2 declined to name a designated representative. R3 R3's personal service plan, dated February 10, 2023, indicated R3's services included medication administration, dependence for activities of daily living (ADLs), assistance with dressing, grooming, showering, toileting, and escorts. R3's residency agreement dated October 8, 2020, did not contain a notice with the required statutory language for R3 to identify a designated	0 950		

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0 950	Continued From page 16 representative or documentation that R3 declined to name a designated representative. On March 7, 2023, at 1:47 p.m., licensed assisted living director (LALD)-A verified R2 and R3's records lacked documentation they had designated or declined to name a representative. LALD-A confirmed the inconsistencies in the contracts and stated, "the company had added the designation of representative to the contract, but we had not used the new contract on any of the resident's yet." The licensee's MN Resident Move-In Packet Checklist dated December 2022, indicated licensee would use the correct Residency Agreement form located in the licensee's move-in packet and the licensee would provide a copy of the consent/declination form to resident's and their family members. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor 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	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30690	A. BUILDING: _____ B. WING _____	03/08/2023

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0 970	Continued From page 17 by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for resident health, safety, or personal property. This had the potential to affect all 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: R2 During R2's record review on March 7, 2023, at 12:20 p.m., R2's residency agreement dated January 19, 2022, included a section for liability that read, "You understand and agree to assume the risks inherent in this Agreement. You agree to hold us, our associates, and agents harmless for any damages, injury or other loss resulting from: (1) reasonable acts or omissions made in good faith; (2) action by a third party, fire, water, theft, or the elements; or (3) loss of personal property." R3 During R3's record review on March 7, 2023, at 2:30 p.m., R3's residency agreement dated October 8, 2020, included a section for liability that read, "You understand and agree to assume the risks inherent in this Agreement. You agree to hold us, our associates, and agents harmless for any damages, injury or other loss resulting from: (1) reasonable acts or omissions made in good	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 970	Continued From page 18 faith; (2) action by a third party, fire, water, theft, or the elements; or (3) loss of personal property." R4 During R4's record review on March 8, 2023, at 10:00 a.m., R4's residency agreement dated October 6, 2022, included a section for liability that read, "You understand and agree to assume the risks inherent in this Agreement. You agree to hold us, our associates, and agents harmless for any damages, injury or other loss resulting from: (1) reasonable acts or omissions made in good faith; (2) action by a third party, fire, water, theft, or the elements; or (3) loss of personal property." R5 During R5's record review on March 8, 2023, at 10:30 a.m., R5's residency agreement dated July 5, 2022, included a section for liability that read, "You understand and agree to assume the risks inherent in this Agreement. You agree to hold us, our associates, and agents harmless for any damages, injury or other loss resulting from: (1) reasonable acts or omissions made in good faith; (2) action by a third party, fire, water, theft, or the elements; or (3) loss of personal property." On March 8 22, 2023, at 11:44 a.m., during the exit conference, licensed assisted living director (LALD)-A confirmed the licensee's assisted living contract included the above content, and stated the same contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02040	Continued From page 19	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted March 8, 2023, at approximately 1:30 p.m. with maintenance	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02040	Continued From page 20 manager (MM)-G on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. This deficient condition was verified by MM-G during the interview at approximately 1:45 p.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *03/07/23*
Time: 12:00:53
Report: 1029231037

Food and Beverage Establishment Inspection Report

Location:
Brookdale Plymouth
15855 22nd Avenue North
Plymouth, MN55447
Hennepin County, 27

Establishment Info:
ID #: 0037658
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634768200
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.

3-500B Microbial Control: hot and cold holding
3-501.16A1 ***** Priority 1 *****

MN Rule 4626.0395A1 Maintain all hot, TCS foods at 135 degrees F (57 degrees C) or above. Roasts may be held at 130 degrees F (54 degrees C) or above if cooked or reheated in accordance with the specified time and temperature requirements in 4626.0340B.

Hot held cooked fish measured 100°F. The only fish found in the danger zone had been placed above the markings of the main metal holder and had been cut up. The lower fish that was uncut measured 136-160°F. Instructed Chris to have items held lower.

Comply By: 03/07/23

3-500B Microbial Control: hot and cold holding
3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

Butter held on counter without a time as a public health control procedure measured 60°F and was set out at ~9am. Instructed Chris to use or discard the butter by 3pm. Chris indicated that the butter was set to be used for a cheese sauce after lunch.

Comply By: 03/07/23

4-500 Equipment Maintenance and Operation
4-501.114C3 ***** Priority 1 *****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

Quaternary ammonium solution in bucket measured ~100 ppm. Dispenser measured ~300 ppm. Corrected during inspection. Instructed Chris to have the buckets changed at a greater frequency depending on usage.

Comply By: 03/07/23

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

3-304.14D

MN Rule 4626.0285D Provide an approved sanitizing solution for storage of the wet wiping cloths that is free of food debris and visible soil.

Towels not in use and stored in a bucket with soapy water. Instructed Chris to keep wet towels in sanitizer solution when not in use. Corrected during inspection.

Comply By: 03/07/23

Surface and Equipment Sanitizers

hot water: = at 166 Degrees Fahrenheit
Location: dishwasher
Violation Issued: No

quaternary ammonium: = 100 ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: Yes

quaternary ammonium: = 150 ppm at Degrees Fahrenheit
Location: sanitizer bucket
Violation Issued: Yes

quaternary ammonium: = 300 ppm at Degrees Fahrenheit
Location: sanitizer dispenser
Violation Issued: No

Food and Equipment Temperatures

Process/Item: butter
Temperature: 60 Degrees Fahrenheit - Location: on counter
Violation Issued: Yes

Process/Item: battered baked fish
Temperature: 136 Degrees Fahrenheit - Location: steam table (deeper in pan)
Violation Issued: No

Process/Item: battered baked fish
Temperature: 160 Degrees Fahrenheit - Location: steam table (deeper in pan)
Violation Issued: No

Process/Item: battered baked fish - cut
Temperature: 100 Degrees Fahrenheit - Location: steam table (higher in pan above markings)
Violation Issued: Yes

Process/Item: hash brown
Temperature: 178 Degrees Fahrenheit - Location: steam table
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: peas and corn
Temperature: 183 Degrees Fahrenheit - Location: steam table
Violation Issued: No

Process/Item: bagged mashed potatoes
Temperature: 38 Degrees Fahrenheit - Location: walk-in cooler
Violation Issued: No

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

Conducted inspection of food services area at Brookdale Plymouth as part of a Health Regulation Division ("HRD") survey. Inspection was conducted with Christine "Chris" Cabor, Dining Services Coordinator/CFPM, and other staff members. All identified issues were discussed with Chris during and after the inspection. Employee illness reporting and exclusion, vomit/fecal matter cleanup procedures, and general food safety were also discussed in addition to time as a public health control, sanitizing, and holding temperatures. Foodborne illness causing pathogens were also discussed with an emphasis on antibiotic resistant shigella.

Some of the baked fish, that was chopped after baking, was found to be held above the pan markings in the steam table insert and in the danger zone (100°F). The fish below the pan markings, and all other hot held items were at 136°F or above. I instructed Chris to store the hot holding items below the markings to maintain all hot held foods at 135°F or above. The food service was less than one hour and all hot held items were served or discarded. Despite the improper holding temperatures due to insert placement and cutting, the fish could not enter the log phase due to the short lunch service. Butter was placed on the counter at 9:00 a.m. and measured 60°F at 12:15 p.m. I instructed Chris to implement a written Time as a Public Health Control ("TPHC") procedure if they intended on softening butter not as part of the food preparation/baking process, and to discard the butter by 3:00 p.m.

Information on TPHC, sanitizing, common foodborne illness pathogens, other general food safety information was emailed to Chris following the inspection.

All identified issues were discussed with Lead HRD Nurse Evaluator, Rhonda Makela, RN, after the inspection.

Food and Beverage Establishment Inspection Report

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 1029231037 of 03/07/23.

Certified Food Protection Manager Christine M. Cabor

Certification Number: FM113554 Expires: 11/01/25

Signed: CCabor

Christine Cabor
Dining Services Coordinator

Signed: Trevor L McCliment

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231037

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	3	Date	03/07/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:53
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Brookdale Plymouth	15855 22nd Avenue North	Plymouth, MN	55447	7634768200

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037658		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) CCabo **Date:** 03/07/23

Inspector (Signature) Samuel McClintock