Electronically Delivered

December 6, 2022

Administrator
Sterling Park Senior Living
114 North 1st Street
Waite Park, MN 56387

RE: Project Number(s) SL24102015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 3, 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, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

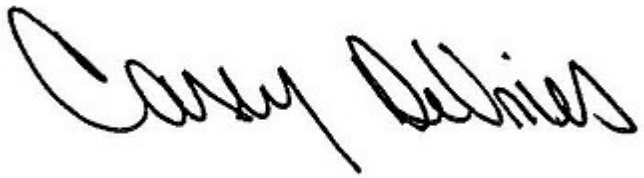
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.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

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

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

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,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 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
	24102	A. BUILDING: _____ B. WING _____	11/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK SENIOR LIVING	114 NORTH 1ST STREET WAITE PARK, MN 56387

(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(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: SL24102015-0 On October 31, 2022, through November 3, 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 77 residents, 69 receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 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: 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 October 31, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health	0 500		

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0 500	Continued From page 3 professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required, 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: During entrance conference on October 31, 2022, at approximately 10:02 a.m., assisted living director in residency (ALDIR)-J stated she reviewed the current assisted living regulations online. The licensee failed to ensure the following policies and procedures were in place and kept	0 500		

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0 500	Continued From page 4 current: -conducting and handling background studies on employees; -a process for evaluating staff performance; -reminders for medications, treatments, or exercises, if provided; -conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; -ensuring that nurses and licensed health professionals have current and valid licenses to practice; -medication and treatment management; and -supervision of registered nurses and licensed health professionals. On November 3, 2022, at 12:22 p.m., clinical nurse specialist (CNS)-I stated the licensee provided all of the policies they had available, and the above policies were not found. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must	0 660		

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0 660	Continued From page 5 include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including evidence of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of four employees (unlicensed personnel (ULP)-D), and lacked documentation of a completed health history and symptom screening for two of four employees (ULP-F, and assistant director of nursing (ADON)-H). 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: The licensee's facility risk assessment dated July 1, 2022, indicated the facility was a low risk.	0 660		

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0 660	Continued From page 6 ULP-D ULP-D was hired under the comprehensive home care license on May 23, 2018, and began providing assisted living services on August 1, 2021. ULP-D's employee record lacked evidence of: - two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test. ULP-F ULP-F was hired to provide assisted living services on July 11, 2022. ULP-F's employee record lacked evidence of: - documentation of a completed health history and symptom screening. ADON-H ADON-H was hired to provide assisted living services on August 10, 2022. ADON-H's employee record lacked evidence of: - documentation of a completed health history and symptom screening. On November 3, 2022, at 3:25 p.m., ADON-H stated employee records should contain a completed history and symptom screening and evidence of TB screening before they work with residents. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated	0 660		

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0 660	Continued From page 7 within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's TB Infection Control Plan (144G) policy, revised August 2021, indicated TB screenings were required for all employees who share the same air space as the resident/tenant, both paid and unpaid, at the time of hire or more often as indicated. In addition, the policy directed baseline TB screening consisted of assessing for current symptoms of active TB disease, assessment of TB history, and testing for the presence of tuberculosis by administering the two-step TST or single IGRA. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require	0 730		

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0 730	Continued From page 8 documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R6).	0 730		

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0 730	Continued From page 9 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: R6's diagnoses included congestive heart failure, major depressive disorder, anxiety, and behavioral concerns. R6 began receiving services on January 6, 2021, and was discharged on July 13, 2022. R6's Level of Care Tool, dated May 13, 2022, indicated R6 received services including medication administration, daily weights, housekeeping, weekly linen/towel laundry with bedmaking, monthly toenail trim, whirlpool weekly, meals, and daily wound care and wrap to left elbow. R6's progress notes, dated June 23, 2022, indicated R6 was admitted to the hospital after a change in status, and multiple falls. R6 passed away at the hospital on July 13, 2022. R6's record lacked evidence a discharge summary was completed at the time of discharge. On November 1, 2022, licensed practical nurse (LPN)-A stated the discharge summary was not completed until the surveyor requested to review the discharge summary on October 31, 2022.	0 730		

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0 730	Continued From page 10 The licensee lacked a policy that addressed the resident's discharge summary, including the required content. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
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:	0 780		

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0 780	Continued From page 11 Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected in some resident's apartments. 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 the potential to affect a large portion or all residents). The findings include: On November 3, 2022, between 10:15 a.m. and 1:00 p.m., survey staff toured the facility with assisted living director in residency (ALDIR)-J and director of maintenance (DM)-G. During the facility tour, survey staff observed smoke alarms in some of the resident apartments were not interconnected so that actuation of one alarm caused all alarms in the dwelling to actuate. ALDIR-J and DM-G verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21)	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,	0 800		

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STERLING PARK SENIOR LIVING	114 NORTH 1ST STREET WAITE PARK, MN 56387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 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 facility 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, 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 residents). The findings include: On November 02, 2022, from approximately 10:15 a.m. to 12:45 p.m., survey staff toured the facility with assisted living director in residency (ALDIR)-J and director of maintenance (DM)-G. During the facility tour, survey staff observed and verified the following maintenance issues: 1. The fire rated doors in some of the resident rooms and laundry rooms was propped open with a door wedge. 2. Mechanical room in the common park wing on second floor is missing sheetrock on the ceiling above the electrical panel in two places. 3. Trash chute door in the lower-level termination room was in disrepair. The door was altered and	0 800		

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0 800	Continued From page 13 did not function or close as designed. ALDIR-J and DM-G verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

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01060	Continued From page 14 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for three of three residents (R1, R3, and R6) hospitalized. 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: R1, R3, and R6's records lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated	01060		

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01060	Continued From page 15	01060		

and any new service provider;
- contact information for the Office of Ombudsman for Long-Term Care (OOLTC);
- if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and
- a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal.

R1
R1's diagnoses included congestive heart failure (CHF).

R1's Service Agreement dated December 2, 2021, noted services including blood sugar monitoring and medication management.

R1's Progress Notes noted:
- September 27, 2022, R1's primary care provider sent R1 to the emergency room for evaluation due to shortness of breath;
- September 28, 2022, R1 was admitted to the observation unit at the hospital on September 27, 2022; and
- September 29, 2022, R1 returned to the facility.

R3
R3's diagnoses included CHF.

R3's Service Agreement dated September 9, 2021, noted services including assistance with showering and dressing and medication management.

R3's Progress Notes noted:
- September 12, 2022, resident was found on the

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01060	Continued From page 16	01060		

floor and transported to the emergency room for weakness, and was admitted for pain management; and
- September 14, 2022, resident returned to the facility.
R6
R6's diagnoses included CHF, anxiety, and behavioral concerns.

R6's Amendment to Addendum A (Section IV-2), identified as the service plan, dated April 13, 2022, noted services including daily vital signs, daily safety checks, daily weight, assistance with bathing, housekeeping and laundry, and medication administration.

R6's Progress Notes noted:
-On June 6, 2022, R6 was too weak to stand and had shaking/tremors to bilateral arms. R6 had oxygen saturation of 80% on 3 liters of oxygen per nasal cannula. R6 was transported to the emergency room via ambulance for further evaluation.
-On June 17, 2022, documentation noted R6 was hospitalized June 6, 2022, through June 10, 2022, for chronic respiratory failure, acute kidney injury, and dehydration, and then was discharged to a rapid recovery unit for physical and occupational therapy. R6 returned to the facility on this date.

On November 1, 2022, at 3:35 p.m., regional licensed assisted living director (LALD)-B stated the licensee was not currently providing a notice when residents were hospitalized and stated they were not aware the Office of Ombudsman for Long-Term Care needed to be notified if the resident was relocated and had not returned to the facility within four days.

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01060	Continued From page 17 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for	01440		

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01440	Continued From page 18 one of two employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F's record lacked evidence to document an appropriate licensed professional or registered nurse provided direct supervision of staff performing delegated tasks as required. ULP-F was hired on July 11, 2022, to provide assisted living services. On November 3, 2022, at 2:30 p.m., assistant director of nursing (ADON)-H said they were not able to find documentation a supervision had been completed on this employee as required. The licensee's Delegation and Supervision of unlicensed personnel policy dated August 1, 2021, noted the ULP must be supervised by a registered nurse within 30 days of working for the assisted living and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01470	Continued From page 19	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	01470		

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01470	Continued From page 20 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for four of four employees (unlicensed personnel (ULP)-D, ULP-F, ULP-E, and assistant director of nursing (ADON)-H). 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:	01470		

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01470	Continued From page 21 ULP-D ULP-D started employment on May 23, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-D's employee record lacked documented evidence of the following: - overview of assisted living statutes; - a review of the provider's policies and procedures; and - assisted living bill of rights. ULP-F ULP-F was hired on July 11, 2022, to provide assisted living services. ULP-F's employee record lacked documented evidence of the following: - a review of the provider's policies and procedures; and - a review of the types of assisted living services the employee would be providing and the facility's category of licensure. ULP-E ULP-E started employment on January 13, 2010, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-E's employee record lacked documented evidence of the following: - overview of assisted living statutes; - a review of the provider's policies and procedures; and - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints.	01470		

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01470	Continued From page 22 ADON-H ADON-H started employment on August 10, 2022, to provide supervision and assisted living services to the licensee's residents. ADON-H's employee record lacked documented evidence of the following: - overview of assisted living statutes; and - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints. On November 3, 2022, at 2:37 p.m., business office manager (BOM)-K stated the employee records lacked the above content. The licensee's Orientation for Assisted Living Staff policy dated August 1, 2021, noted all staff providing and supervising direct care service must complete an orientation to assisted living facility licensure requirements and regulations prior to providing assisted living services to residents, and the orientation must include an overview of the statutes, introduction and review of all the provider's policies and procedures related to the provision of services, the assisted living bill of rights, and a review of the types of assisted living services the employee would be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED	01530		

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01530	Continued From page 23 (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of four employees (unlicensed personnel (ULP)-F) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01530		

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01530	Continued From page 24 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: The licensee provided services under an assisted living license. During the entrance conference on October 31, 2022, at 10:00 a.m., assisted living director in residency (ALDIR)-J stated the licensee did not have a secure dementia unit, but did provide services to residents with the diagnosis of dementia. ULP-F was hired on July11, 2022, to provide assisted living services to the licensee's residents. ULP-F's employee record contained evidence of four hours of dementia training upon hire, short of the required eight hours of training within 160 working hours. On November 3, 2022, at 3:35 p.m., assistant director of nursing (ADON)-H stated all direct care staff were provided four hours training within 160 hours, and said ULP-F reached 160 working hours on August 19, 2022. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01560 SS=F	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED	01560		

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01560	Continued From page 25 (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, the dementia care training program with the required content. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 provided services under an assisted living license.	01560		

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01560	Continued From page 26 During the entrance conference on October 31, 2022, at 10:00 a.m., the surveyor requested a copy of the dementia training program notice. On November 3, 2022, at 1:15 p.m., clinical nurse supervisor (CNS)-I stated she was unable to locate a written notice of the dementia care training program. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a	01620		

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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 comprehensive resident reassessment and monitoring no more than 14 calendar days after initiation of services for one of five residents (R5), and within 90 calendar days from the last assessment for one of five residents (R4).

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:

R5
R5 was admitted for services on March 23, 2022, with diagnoses including paranoid schizophrenia.

R5's Service Agreement dated March 23, 2022, noted services including blood sugar monitoring and medication management.

R5's Nursing Assessment dated March 23, 2022, noted the resident required assistance with donning and doffing clean shoes and socks, encouragement to perform hygiene tasks, and medication management. R5's record also

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01620	Continued From page 28 contained a Master Assessment - Condensed dated March 23, 2022. R5's record contained a Nursing Assessment and Master Assessment - Condensed dated April 19, 2022, (27 days later). R5's record lacked a reassessment and monitoring no more than 14 calendar days after initiation of services as required. On November 3, 2022, at 9:20 a.m., assistant director of nursing (ADON)-H stated R5's record lacked a 14-day reassessment and monitoring. In addition, ADON-H stated she had to complete both nursing assessments to ensure it contained the required content, and was in the process of working with the electronic record company to incorporate the assessments all into one tool. R4 R4 was admitted for services on July 11, 2019, with diagnoses including acute and chronic respiratory failure. R4 had a contract signed August 1, 2021. R4's Service Agreement, dated July 1, 2021, indicated R4 required assistance with exercise program, medical monitoring, meal reminders, nebulizer reminder, laundry, housekeeping, medication administration, and oxygen safety check. R4's record included a Nursing Assessment, dated February 25, 2022, identified as a "Change in Condition," and a Master Assessment-Condensed, dated May 26, 2022, identified as a "90 Day Assessment," which did not include components of a uniform assessment tool, as required. R4's record lacked evidence a 90-day reassessment had been completed since	01620		

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01620	Continued From page 29 then (164 days later). On November 3, 2022, at 10:37 a.m., ADON-H stated a 90-day comprehensive reassessment was not completed timely for R4, and stated both assessments would need to be completed to ensure it contained the required content of the uniform assessment tool. The licensee's Comprehensive Nursing Assessment Schedule policy dated August 1, 2021, noted client [resident] monitoring and reassessment/initial review would be completed within 14 days after initiation of services and at least every 90 days. 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 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	01650		

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01650	Continued From page 30 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 interview and record review, the licensee failed to ensure a service plan included the required content for five of five residents (R1, R3, R5, R2, and R4). 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, R3, R5, R2, and R4's records lacked a service plan to include the following required content: - schedule and methods of monitoring reviews or assessments of the resident; and - methods of monitoring staff providing services. R1	01650		

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01650	Continued From page 31 R1's diagnoses included congestive heart failure (CHF). R1's Service Agreement dated December 2, 2021, noted services including blood sugar monitoring and medication management. The agreement noted: - the registered nurse (RN) would complete an initial individual assessment within five days after the initiation of services; and - supervision of unlicensed personnel would be conducted by the RN within 30 days of hire and as needed based on performance. R3 R3's diagnoses included CHF. R3's Service Agreement dated September 9, 2021, noted services including assistance with showering, dressing, and medication management. The agreement noted: - the RN would complete an initial individual assessment within five days after the initiation of services; and - supervision of unlicensed personnel would be conducted by the RN within 30 days of hire and as needed based on performance. R5 R5's diagnoses included paranoid schizophrenia. R5's Service Agreement dated March 23, 2022, noted services including blood sugar monitoring and medication management. The agreement noted: - the RN would complete an initial individual assessment within five days after the initiation of services; and - supervision of unlicensed personnel would be conducted by the RN within 30 days of hire and	01650		

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as needed based on performance.
R2
R2's diagnoses included cognitive impairment and Parkinson's Disease.

R2's Service Agreement, dated June 30, 2021, noted services including medication management, assistance with shower, housekeeping, and laundry. The agreement noted:
- the RN would complete an initial individual assessment within five days after the initiation of services; and
- supervision of unlicensed personnel would be conducted by the RN within 30 days of hire and as needed based on performance.

R4
R4's diagnoses included acute and chronic respiratory failure.

R4's Service Agreement, dated July 1, 2021, indicated R4 required assistance with exercise program, medical monitoring, meal reminders, nebulizer reminder, laundry, housekeeping, medication administration, and oxygen safety check. The agreement noted:
- the RN would complete an initial individual assessment within five days after the initiation of services; and
- supervision of unlicensed personnel would be conducted by the RN within 30 days of hire and as needed based on performance.

On November 3, 2022, at 9:50 a.m. assistant director of nursing (ADON)-H stated the service plan contained the comprehensive home care assessment language, and lacked the method of supervision the unlicensed personnel. In addition, ADON-H indicated the same service plan

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01650	Continued From page 33 agreement template was utilized for all residents. The licensee's Service Plan Modification policy dated August 2021 noted the service plan would include the schedule and methods of monitoring reviews or assessments of the resident and the frequency of sessions of supervision of staff and the type of personnel who would supervise staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and	01690		

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01690	Continued From page 34 designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain current medication management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines. 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 October 31, 2022, at 10:02 a.m., assisted living director in residence (ALDIR)-J indicated the licensee provided medication management services to the licensee's residents. The provided policies and procedures lacked	01690		

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01690	Continued From page 35 medication management policies to address the following: - educating resident and legal and designated representatives about medications. On November 3, 2022, at 12:22 p.m., clinical nurse supervisor (CNS)-I indicated the licensee had provided all of the policies and procedures related to medication management services and lacked the above content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were transcribed as prescribed for one of five residents	01760		

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01760	Continued From page 36 (R4). 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: R4's Service Agreement, dated July 1, 2021, indicated R4 required assistance with exercise program, medical monitoring, meal reminders, nebulizer reminder, laundry, housekeeping, oxygen safety check, and medication administration On November 1, 2022, at 1:43 p.m., the surveyor observed unlicensed personnel (ULP)-C administer acetaminophen (pain reliever) 500 mg (milligrams) two tablets orally, to R4. R4's Bluestone Physician Services orders, dated April 5, 2022, included acetaminophen 500 mg tablet, take two tablets by mouth three times daily. R4's Medication Sheet, dated October 2022, included acetaminophen 500 mg two tablets by mouth "TWICE" daily and indicated staff should administer at 8:00 a.m., 2:00 p.m., and 8:00 p.m. On November 3, 2022, at 10:37 a.m., assistant director of nursing (ADON)-H stated the directions for the acetaminophen had changed and were incorrectly transcribed onto the	01760		

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01760	Continued From page 37 medication administration record, and stated could be confusing to staff administering the medication. The licensee's Medication & Treatment Orders, Guideline, dated August 2021, indicated upon receipt of a medication order, whether new or change of an order from an authorized prescriber, a licensed nurse must take action to implement the order within 24 hours, and the content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may	01790		

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01790	Continued From page 38 delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the	01790		

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01790	Continued From page 39 doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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: During the entrance conference on October 31, 2022, at 10:02 a.m. assisted living director in residence (ALDIR)-J indicated the licensee provided medication management services to the licensee's residents. The licensee's written procedure titled Medication Administration, Guideline, dated July 2022, under subtitle Outings & Unplanned Leave of Absences, lacked the following: - how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.	01790		

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01790	Continued From page 40 On November 3, 2022, at 12:22 p.m., clinical nurse supervisor (CNS)-I indicated the licensee had provided all of the policies and procedures related to medication management services; however, lacked the above content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and/or document medication refrigerator temperatures for one of one medication refrigerator. 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:	01880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STERLING PARK SENIOR LIVING	114 NORTH 1ST STREET WAITE PARK, MN 56387

(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
01880	Continued From page 41 During the entrance conference on October 31, 2022, at 10:02 a.m. assisted living director in residence (ALDIR)-J indicated the licensee provided medication management services to the licensee's residents, including medication storage. On November 3, 2022, at 2:08 p.m., assistant director of nursing (ADON)-H opened the small, dorm type medication refrigerator in the nurse's office. The surveyor observed ice build-up around the freezer space in the upper right-hand corner of the refrigerator and down the right inside wall of the refrigerator, and noted a digital thermometer on the top shelf: however, the screen was dark with no display. ADON-H stated there was no process in place to monitor the temperature; however, stated the staff look at the thermometer all the time when they opened the refrigerator to ensure it was within the correct temperature range, which she stated should be between 36-45 degrees Fahrenheit (F). ADON-H stated the battery must have recently died. The refrigerator contained one bottle of Adacel (prevent tetanus, diphtheria, pertussis) vaccine, Boostrix (prevent tetanus, diphtheria, pertussis) vaccine, two Shingrix (prevent shingles) vaccine, Prevnar (prevent bacterial infection) vaccine, Vaxneuvance (prevention of invasive disease) vaccine, one Tresiba (long acting insulin) FlexTouch pen, two Ozempic (weekly injection to help control blood sugar) injection pens, three Victoza (treat type 2 diabetes) injections, 12 Lantus Solostar (long acting insulin) pens, 25 Novolog (short acting insulin) FlexPens, and 15 Basaglar (long acting insulin) pens. On November 3, 2022, at 4:23 p.m., ADON-H stated she had placed a new thermometer in the	01880		

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	24102	A. BUILDING: _____ B. WING _____	11/03/2022

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STERLING PARK SENIOR LIVING	114 NORTH 1ST STREET WAITE PARK, MN 56387

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01880	Continued From page 42	01880		

refrigerator and the current temperature was 45.2 degrees F.

The manufacturer's instructions for Adacel antigen, dated January 7, 2022, indicated it should be stored at 35 to 46 degrees F. If product has been exposed to freezing, it should not be used.

The manufacturer's instructions for Boostrix, dated October 12, 2022, indicated storage in the refrigerator between 36-46 degrees F. Do not freeze. Discard if the vaccine has been frozen.

The manufacturer's instructions for Shingrix, dated January 25, 2018, indicated storage in the refrigerator ideally at 40 degrees F. Never freeze refrigerated vaccines.

The manufacturer's instructions for Prevnar, dated January 24, 2022, indicated storage in the refrigerator between 36-46 degrees F. Do not freeze.

The manufacturer's instructions for Vaxneuvance, dated June 2022, indicated storage in the refrigerator between 36-46 degrees F. Do not freeze.

The manufacturer's instructions for Tresiba, dated October 2022, indicated storage in the refrigerator between 36-46 degrees F. Do not freeze.

The manufacturer's instructions for Ozempic, dated July 7, 2022, indicated storage in the refrigerator between 36-46 degrees F. Do not freeze.

The manufacturer's instructions for Victoza,

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01880	Continued From page 43 November 1, 2022, indicated the insulin is highly sensitive to extreme temperatures, and should be stored in the refrigerator between 36-46 degrees F. Do not expose to temperatures below 36 degrees F, or the insulin will lose effectiveness and cannot be used anymore. The manufacturer's instructions for Lantus Solostar, dated May 2022, indicated unused pens should be refrigerated between 36-46 degrees F. Do not freeze. The manufacturer's instructions for Novolog FlexPens, dated November 1, 2022, indicated storage in the refrigerator at 36-46 degrees F until first use. Avoid freezing. The manufacturer's instructions for Basaglar, dated September 2021, indicated unused pens should be refrigerated between 36-46 degrees F, and not used if allowed to freeze. The licensee's Medication Operational Procedures, Guideline, dated August 2021, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy	01930		

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01930	Continued From page 44 management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines. 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 October 31, 2022, at 10:02 a.m. assisted living director in	01930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01930	Continued From page 45 residence (ALDIR)-J indicated the licensee provided treatment and therapy management services to the licensee's residents. The licensee lacked policies and procedures that addressed: - documenting treatment or therapy activities; - educating and communicating with residents about treatments or therapies they are receiving; - monitoring and evaluating the treatment or therapy; and - communicating with the prescriber. On November 3, 2022, at 12:22 p.m., clinical nurse supervisor (CNS)-I indicated the licensee had provided all of the policies and procedures related to treatment and therapy management services; however, lacked the above content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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01940	Continued From page 46 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R4). 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: During the entrance conference on October 31,	01940		

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01940	Continued From page 47 2022, at 10:02 a.m., assisted living director in residence (ALDIR)-J indicated the licensee provided treatment and therapy management services to the licensee's residents, including blood glucose checks, oxygen assistance, and compression stockings. R4's record lacked a treatment management plan to include the following required content: - a statement of the type of service that would be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that would be delegated to unlicensed personnel; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R4 had a contract signed August 1, 2021. R4's Service Agreement, dated July 1, 2021, indicated R4 required assistance with exercise program, medical monitoring, meal reminders, nebulizer reminder, laundry, housekeeping, medication administration, and oxygen safety check. R4's prescriber orders dated July 10, 2019, included oxygen at 2 liters per nasal cannula. In addition, R4's prescriber orders, date September 27, 2022, included compression stockings, on in the morning, off in the evening for lower extremity	01940		

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01940	Continued From page 48 edema. On November 2, 2022, at 3:41 p.m., the surveyor observed unlicensed personnel (ULP)-C while she administered an oral medication to R4. R4 had a nasal cannula in place with a long green tubing connected to the oxygen concentrator in R4's room. R4 was not wearing compression stockings, as ordered. R4 stated the compression stockings had come in the mail last week and they were somewhere on his counter in the kitchen, unopened. ULP-C stated she was unaware that R4 should be wearing compression stockings and stated this task was not listed on her tablet as a service she needed to provide. On November 2, 2022, at 4:10 p.m., assistant director of nursing (ADON)-H stated she was aware of the order for compression stockings, and she confirmed the arrival of the compression stockings the prior week; however, a treatment management plan with the required content had not been developed for R4. The licensee's Medication & Treatment Orders, Guideline, dated August 2021, indicated medication and treatment orders received must be implemented within 24 hours of receipt, and the registered nurse was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff were kept on file in the residents' records. The guideline lacked direction to develop and maintain a current individualized treatment and therapy management record for each resident, with the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940		

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01940	Continued From page 49 days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for two of five residents (R1 and R4). 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	01950		

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01950	Continued From page 50	01950		

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:

R1
R1's diagnoses included congestive heart failure (CHF).

On November 1, 2022, at 11:10 a.m., the surveyor observed unlicensed personnel (ULP)-D perform a blood glucose check on R1 in her apartment. At this time, the reading came back as 600 milligrams (mg)/deciliter (dL). R1 stated she had just eaten candy bars, and had brown sugar and coffee cake earlier. ULP-D then administered 7 units Novolog FlexPen and went to the electronic record. ULP-D stated there were no parameters or instructions on R1's record when to notify the nurse, but did tell R1 she would report this. In addition, ULP-D stated other residents with blood glucose checks have parameters in their record, so she was not sure why there were none for R1. ULP-D stated this was a very high reading that she would report. After exiting the resident's apartment, ULP-D reported the reading to ULP-E, identified as the lead ULP.

On November 1, 2022, at 1:35 p.m., ULP-E stated when out of range blood glucose levels were reported to her, she informs the provider and the licensed practical nurse (LPN). In addition, ULP-E stated they have parameters for all residents and do annual training for staff to

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01950	Continued From page 51	01950		

report when the reading is high, which she identified would be 500 mg/dL.

On November 1, 2022, at 2:05 p.m. LPN-A stated some residents have blood glucose parameters and staff are to notify nursing of any reading above 400 mg/dL. At this time LPN-A found parameters for R1 on her computer which read "If BS [blood sugar] below 70 or above 400 update floor nurse IMMEDIATELY, if no floor nurse call the on-call RN". At 4:00 p.m., LPN-A returned and stated the instructions for R1 do not show up on the tablets utilized by the ULP.

R4

R4's diagnoses included acute and chronic respiratory failure.

R4 had a contract signed August 1, 2021.

R4's Service Agreement, dated July 1, 2021, indicated R4 required assistance with exercise program, medical monitoring, meal reminders, nebulizer reminder, laundry, housekeeping, medication administration, and oxygen safety check.

R4's prescriber orders dated July 10, 2019, included oxygen at 2 liters per nasal cannula. In addition, R4's prescriber orders, date September 27, 2022, included compression stockings, on in the morning, off in the evening for lower extremity edema.

On November 2, 2022, at 3:41 p.m., the surveyor observed ULP-C while she administered an oral medication. R4 had nasal cannula in place with a long green tubing connected to the oxygen concentrator in R4's room. R4 was not wearing compression stockings, as ordered. R4 stated the compression stockings had come in the mail last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 52 week and they were somewhere on his counter in the kitchen, unopened. ULP-C stated she was unaware that R4 should be wearing compression stockings and stated this task was not listed on her tablet as a service she needed to provide. On November 2, 2022, at 4:10 p.m., assistant director of nursing (ADON)-H stated she was aware of the order for compression stockings, and she confirmed the arrival of the compression stockings the prior week; however, a treatment management plan with the required content had not been developed for R4 and the compression stockings had not been implemented, as ordered. The licensee's Medication & Treatment Orders, Guideline, dated August 2021, directed medication and treatment orders received must be implemented within 24 hours of receipt, and indicated the registered nurse was responsible for assuring that orders were addressed on the resident's service plan and communicated to staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

DEPARTMENT OF HEALTH

Type: Full
Date: *10/31/22*
Time: 10:44:14
Report: 1037221068

Food and Beverage Establishment Inspection Report

Location:
Sterling Park Senior Living
114 North 1st Street
Waite Park, MN56387
Stearns County, 73

Establishment Info:
ID #: 0037599
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202527224
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

3-501.16A2 ** Priority 1 **

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

HARD BOILED EGGS, SLICED CHEESE, AND PRECOOKED NOODLES WERE 46-48 DEG F IN THE SERVING KITCHEN UPRIGHT COOLER. DISCARD TCS FOOD ITEMS.

Comply By: 10/31/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

PROVIDE A THIN TIP THERMOMETER FOR THE SERVING KITCHEN.

Comply By: 11/30/22

2-100 Supervision

2-102.12AMN

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

EMPLOYEE IS SERVESAFE TRAINED, BUT NOT REGISTERED AS A CFPM. FACT SHEET ATTACHED.

Comply By: 12/30/22

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

3-305.11A

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

BOXES OF BRUSSEL SPROUTS & CAULIFLOWER WERE LOCATED ON THE FLOOR IN THE WALK-IN FREEZER. STORE ALL FOOD ITEMS AT LEAST 6 INCHES ABOVE THE FLOOR

Comply By: 10/31/22

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

APPLE SAUCE BEING STORED IN SOUR CREAM CONTAINER. DISCONTINUE REUSING FOOD CONTAINERS THAT ARE NOT DESIGNED FOR REUSE.

Comply By: 10/31/22

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE SERVING KITCHEN UPRIGHT COOLER IS NOT MAINTAINING TEMPERATURE. FOOD ITEMS 46-48 DEG F, COOLER READING 53 DEG F. DISCONTINUE STORING TCS FOOD ITEMS IN COOLER UNTIL IT IS REPAIRED OR REPLACED.

Comply By: 11/30/22

Surface and Equipment Sanitizers

Hot Water: = at 160.9 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Hot Water: = at 166 Degrees Fahrenheit
Location: DISHWASHER - SERVING KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 180 Degrees Fahrenheit - Location: MASHED POTATOES
Violation Issued: No

Process/Item: Hot Holding
Temperature: 171 Degrees Fahrenheit - Location: BEEF STEW
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 35 Degrees Fahrenheit - Location: CHOCOLATE PUDDING
Violation Issued: No

Process/Item: Hot Holding
Temperature: 178 Degrees Fahrenheit - Location: BEEF STEW- OVEN WARM MODE
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: SLICED CHEESE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 157 Degrees Fahrenheit - Location: BEEF STEW - SERVING KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 48 Degrees Fahrenheit - Location: HARD BOILED EGG
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 46 Degrees Fahrenheit - Location: PRECOOKED NOODLES
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 47 Degrees Fahrenheit - Location: SLICED AMERICAN CHEESE
Violation Issued: Yes

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	4

SERVING KITCHEN IN STERLING PARK ASSISTED LIVING.
KITCHEN IN STERLING PARK NURSING HOME.
CFPM (JULIE ENGELKENS) NOT REGISTERED THROUGH THE STATE OF MINNESOTA - SEND FACT SHEET ON CFPM REGISTRATION. JULIEENGELKENS@GMAIL.COM
REGISTERED DIETICIAN OVERSEES KITCHEN STAFF - ALLISON ROUND

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 inspection report number 1037221068 of 10/31/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed: Michelle L Hovanes

Establishment Representative

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037221068

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	2	Date	10/31/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:44:14
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Sterling Park Senior Living	114 North 1st Street	Waite Park, MN	56387	3202527224

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037599		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	X	Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39	X	Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	X	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) **Date:** 10/31/22

Inspector (Signature) Michelle L Thomas