Electronically Delivered

April 28, 2023

Licensee
Amira Choice Roseville
2996 Cleveland Avenue North
Roseville, MN 55113

RE: Project Number(s) SL28965015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 31, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28965	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE ROSEVILLE	2996 CLEVELAND AVENUE NORTH ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL28965015-0 On March 27, 2023, through March 29, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 80 residents, 57 of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Report," dated March 28, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 2 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control related to perineal care, oral care, and oxgen tubing. 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: PERINEAL CARE AND ORAL CARE On March 28, 2023, between 10:06 a.m. and 10:30 a.m., while R3 was lying in bed, surveyor observed ULP-B perform improper wiping techniques (wiping back to front) after R3 had a bowel movement which could increase the risk for urinary tract infection. Following perrineal cares, ULP-B assisted R3 into the bathroom for	0 510		

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0 510	Continued From page 3 additional morning cares. After R3 completed teeth brushing, ULP-B placed the toothbrush directly into the bathroom sink. After cares were done, ULP-B then rinsed the toothbrush with water and put it away. ULP-B was hired on November 14, 2022, and was a certified nursing assistant through the Minnesota Department of Health. ULP-B's New Employee Orientation Competency Testing dated November 16, 2022, deemed ULP-B competent in personal cares such as "care of teeth, gums and oral prosthetic devices," and "dressing and assisting with toileting." During an interview on March 28, 2023, at 10:36 a.m., surveyor asked if it was sanitary to put a toothbrush into the sink and asked if staff used that same sink for handwashing. ULP-B replied, "yes, they do wash their hands here and I realize I shouldn't do that." ULP-B also acknowledged the improper wiping techniques. OXYGEN TUBING On March 28, 2023, at 9:30 a.m., surveyor observed an oxygen concentrator machine (condenses room air into oxygen) in R4's room with the nasal cannula (tube with prongs placed inside nose) and extension tube (tube that connects the nasal cannula to the machine) on the floor lying near R4's trash can. Surveyor did not observe any hooks to hang the nasal cannula or plastic bags to place the tubing in. During an interview on March 28, 2023, at 10:47 a.m., ULP-G stated staff usually coiled the tubing and placed it on the machine, but it must have fallen to the floor.	0 510		

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0 510	Continued From page 4 During an interview on March 28, 2023, at approximately 11:00 a.m., director of nursing (DON)-A acknowledged improper wiping techniques were used, and stated the toothbrush should not have been placed in the sink and the nasal cannula for the oxygen tubing must be kept off the floor. The Minnesota Mock Skills document, last updated on May 16, 2022, and linked from the Minnesota Department of Health Nursing Assistant Registry website included skill task steps as guidelines to help those becoming a certified nursing assistant. On page 17 under "Perineal Care For A Female Resident With Hand Washing," it instructed nursing assistants to wash genital area from front to back. The licensee's Orientation and Training: Employee policy dated August 1, 2023, indicated ULPs providing assisted living services would successfully complete a practical skills test to demonstrate competency on the following topics: -care of teeth, gums, and oral prostetic devices; -dressing and assisting with toileting; and -all other delegated tasks the ULP would perform. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an	0 630		

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0 630	Continued From page 5 individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) contained statements of the specific measures to be taken by staff to minimize the risk of abuse for two of four residents (R1, R2). Further, neither resident was identified as a vulnerable adult in their abuse prevention assessments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's service plan dated March 1, 2023, indicated R1 received services for bed mobility, repositioning, toileting, bathing, transfers, and activities of daily living (ADLs). R1's record included a Comprehensive	0 630		

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0 630	Continued From page 6 Assessment dated March 24, 2023, which included a "Vulnerabilities and Abuse Prevention," assessment. The assessment indicated R1 did not have any vulnerabilities. R2 R2's service plan dated March 1, 2023, indicated R2 received services for transfers, toileting, bathing, and ADLs. R2's record included a Comprehensive Assessment dated February 10, 2023, which included a "Vulnerabilities and Abuse Prevention," assessment. The assessment indicated R2 did not have any vulnerabilities. On March 29, 2023, at 9:04 a.m., licensed assisted living director (LALD)-D stated the IAPP's could be found in the comprehensive assessment. On March 29, 2023, at 3:52 p.m., an email from the director of nursing (DON)-A indicated all assisted living and memory care residents should be identified as vulnerable adults. The licensee's Vulnerable Adult Chart - Abuse, Neglect and Financial Exploitation as Defined by the Vulnerable Adult Act policy dated December 2, 2020, indicated: "Definition of Vulnerable Adult Under MN Statute §626.5572, Subd. 21, any person 18 years of age or older who is a home care client is categorically defined as a vulnerable adult. This section of law includes a functional definition of a vulnerable adult: a person who "regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:	0 630		

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0 630	Continued From page 7 (i) That impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and (ii) Because of the dysfunction or infirmity and the need for care or services, the individual has an impaired ability to protect the individual's self from maltreatment." In this definition, "care or services" means care or services for the health, safety, welfare, or maintenance of an individual." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors.	0 800		

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0 800	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 28, 2023, from approximately 10:30 a.m. to 1:00 p.m. with the environmental services director (M)-F it was observed the trash chute doors on the first, second, and third floors did not shut, and latch on their own. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system that connects all levels of the facility. It was observed in the trash collection room that the fusible link was missing on the sliding, trash chute cover at the bottom of the trash chute system. The fusible link ensures the trash chute cover closes automatically in case of a fire starting in the dumpster below. It was observed that the door closer had been disabled by removing the closure arm or closure device. The laundry room door had a portion of the closure device still mounted on the door. The door closure device is required to make the door close and positively latch to maintain the fire resistance integrity of the laundry room and corridor for safety purposes. It was observed that the ceiling tile in the	0 800		

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0 800	Continued From page 9 bathroom adjacent to the dining room in the memory care unit had signs of water damage and dark staining around the sprinkler head. M-F visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.	0 810		

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0 810	Continued From page 10 (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 28, 2023, at approximately 1:15 p.m. with the environmental services director(M)-F on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, M-F stated the	0 810		

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0 810	Continued From page 11 licensee did not have any documented training or a policy on training employees. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, M-F stated that the facility did not have documentation or a policy on offering resident training on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 950	Continued From page 12 (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include verbatim language, on its own separate page, giving residents the right to identify a designated representative for four of four residents (R1, R2, R3, R4). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's record contained a signed contract dated June 23, 2016. R2's record contained a signed contract amended on January 10, 2022. R3's record contained a signed contract dated August 1, 2021. R4's record contained a signed contract amended on December 19, 2021.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28965	A. BUILDING: _____ B. WING _____	03/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMIRA CHOICE ROSEVILLE	2996 CLEVELAND AVENUE NORTH ROSEVILLE, MN 55113

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0 950	Continued From page 13 R1, R2, R3 and R4's contracts listed above lacked the statute required verbatim statement, written on its own page, giving the residents the right to designate their representative. On March 29, 2023, at 9:04 a.m., licensed assisted living director (LALD)-D stated their new contract did have the required designated representative information but acknowledged some residents signed older contracts which did not meet the designated representative requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for four of four residents (R1, R2, R3, R4) reviewed.	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28965	A. BUILDING: _____ B. WING _____	03/31/2023

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0 970	Continued From page 14 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's record contained a signed contract dated June 23, 2016. R2's record contained a signed contract amended on January 10, 2022. R3's record contained a signed contract dated August 1, 2021. R4's record contained a signed contract amended on December 19, 2021. On March 27, 2023, the facility provided a blank copy of their current contract which was undated. R1, R2, R3 and R4's contracts listed above included the following waivers of liability: "SECTION 26.0-PERSONAL PROPERTY. Facility is not responsible for any loss or damage to Resident's personal property due to theft, fire, water, tornado or other acts of nature and events beyond Facility's control, or due to the actions of other Residents. Resident is strongly encouraged to keep items of significant financial or sentimental value stored in a bank safe deposit box, and to obtain renter's insurance." "SECTION 31.0- INDEMNIFICATION. As an	0 970		

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	28965	A. BUILDING: _____ B. WING _____	03/31/2023

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0 970	Continued From page 15 occupant of the Facility, Resident assumes the risk for Resident's own safety and for the safety of Resident's personal property, guests and agents. Resident will indemnify and hold harmless Facility, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident or Resident's guests of the Apartment or any other part of Facility, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." On March 29, 2023, at 9:04 a.m., licensed assisted living director (LALD)-D stated their new contract did not contain the waiver of liability information but acknowledged some residents signed older contracts and did not include an addendum to their contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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 and interview, the licensee failed to lock a medication storage cart which while not in use, or monitored by staff. This had	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28965	A. BUILDING: _____ B. WING _____	03/31/2023

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AMIRA CHOICE ROSEVILLE	2996 CLEVELAND AVENUE NORTH ROSEVILLE, MN 55113

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01880	Continued From page 16 the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 29, 2023, at 10:49 a.m., the surveyor observed an unlocked medication cart in the 3rd floor hallway across from room 314. The push button locking mechanism was popped out with a large red dot visible on the side. The medication cart remained unlocked until unlicensed personnel (ULP)-I exited room 314 at 11:01 a.m., when ULP-I immediately went and pushed in the locking mechanism relocking the medication cart. On March 29, 2023, at 11:01 a.m., ULP-I stated they knew the medication cart was supposed to remain locked when unattended and the licensee provided education to never leave a medication cart unattended when it was unlocked. On March 29, 2023, at 3:52 p.m., director of nursing (DON)-A's email indicated their expectation was for medication carts to be locked at all times when unattended. The licensee's Storage of Medication and Key Security policy dated September 27, 2021, indicated, "Secured Storage of medications is defined as medications stored in a locked cabinet/box or refrigerator the client's [resident's]	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28965	A. BUILDING: _____ B. WING _____	03/31/2023

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AMIRA CHOICE ROSEVILLE	2996 CLEVELAND AVENUE NORTH ROSEVILLE, MN 55113

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01880	Continued From page 17 apartment. All medications administered by staff will generally be kept in the secured storage area." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure unlicensed personnel (ULP) followed appropriate transfer procedures for one of four residents (R3). 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:	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02320	Continued From page 18 R3's diagnoses included hemiplegia affecting right dominant side (paralysis), aphasia (difficulty communicating), dysphagia (difficulty swallowing), anxiety disorder, hypertension, osteoporosis (weak bones) and vascular dementia. R3's Basic Assessment/ULP Services document completed by a registered nurse (RN) dated February 10, 2023, indicated R3 needed physical assistance of two staff with transfers including getting in and out of bed. R3's service plan, signed on November 8, 2022, indicated R3's services included assistance of two staff for all transfers with gait belt. On March 28, 2023, at 10:30 a.m., the surveyor observed ULP-B apply a hard plastic brace to R3's right ankle then apply shoes. ULP-B placed the gait belt (belt to assist with transfers) around R3's waist. ULP-B placed R3's manual wheelchair to the left side of R3's bed, sat R3 up and turned R3 towards the edge of the bed to face ULP-B. ULP-B then stood R3 and proceeded to turn R3 to toward the left in front of the wheelchair. During the process, R3's right foot and leg twisted underneath the left leg due to the paralysis. ULP-B sat R3 into the wheelchair, adjusted R3's legs, removed the gait belt, and applied a foot pedal to right side of the wheelchair. Prior to the transfer, the surveyor did not observe ULP-B attempt to reach any staff for assistance. ULP-B's New Employee Orientation Competency Testing record dated November 16, 2022, indicated ULP-B was deemed competent on transfers from sitting to standing and transfers from wheelchair to bed.	02320		

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02320	Continued From page 19 On March 28, 2023, at 1:15 p.m., ULP-B acknowledged R3 was supposed to be a two-person transfer and stated because the other ULP working in the same unit was on break, ULP-B did a one-person transfer. On March 29, 2023, at 10:23 a.m., director of nursing (DON)-A confirmed R3 was supposed to be a two-person transfer and staff were trained to contact other staff to assist for two-person transfers. DON-A also indicated staff could send out a mass text message that would reach all staff members, including nursing staff, if help was needed. The licensee's Orientation and Training: Employee policy dated August 1, 2023, indicated staff providing assisted living services would be oriented specifically to each individual resident and the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *03/28/23*
Time: 12:57:04
Report: 1021231065

Food and Beverage Establishment Inspection Report

Location:
Cherrywood Pointe Of Roseville
2996 Cleveland Avenue North
Roseville, MN55113
Ramsey County, 62

Establishment Info:
ID #: 0037925
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6516330044
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.

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER BLADE CONTAINS DRIED FOOD DEBRIS AND CAN LABEL SHAVINGS. STAFF WILL SEND THE CAN OPENER TO THE DISH MACHINE. CLEAN AND SANITIZE CAN OPENER AFTER EACH USE.

Comply By: 03/28/23

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

BOTTOM PART OF THE ICE CREAM FREEZER CONTAINS ACCUMULATION OF SPILLED ICE CREAM. CLEAN AND MAINTAIN CLEAN.

Comply By: 04/03/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

DUST ACCUMULATION OBSERVED ON THE DRY STORAGE ROOM CEILING VENT DIFFUSER. CLEAN AND MAINTAIN CLEAN.

Comply By: 04/03/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET, NEXT TO STOVE
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK
Violation Issued: No

Final Utensil Surface Temp: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: SLICED TOMATO - DELFIELD UNDER COUNTER COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: GRILLED CHICKEN - DELFIELD UNDER COUNTER COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 142 Degrees Fahrenheit - Location: GRILLED CHEESE SANDWICH - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 178 Degrees Fahrenheit - Location: TOMATO SOUP - SOUP WELL
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: CUT MELON - SUPERIOR UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SCRAMBLED EGGS - SUPERIOR UPRIGHT COOLER

Violation Issued: No

Process/Item: Cooling
Temperature: 59 Degrees Fahrenheit - Location: PEPPER SOUP - WALK-IN COOLER, COOLING 1 HOUR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: COOKED BEEF - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: COOKED PORK - WALK-IN COOLER
Violation Issued: No

Type: Full
Date: *03/28/23*
Time: 12:57:04
Report: 1021231065
Cherrywood Pointe Of Roseville

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - KELVINATOR UPRIGHT COOLER, MEMORY CARE UPPER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - KELVINATOR UPRIGHT COOLER, MEMORY CARE LOWER
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH KITCHEN MANAGER, NICOLE HEBERT AND HEALTH REGULATION DIVISION NURSE EVALUATORS, JOEY KEEN AND ANNA BOHNEN.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021231065 of 03/28/23.

Certified Food Protection Manager: NICOLE M. HEBERT

Certification Number: FM62725 Expires: 05/11/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
NICOLE HEBERT
KITCHEN MANAGER

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us