DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 31, 2022

Administrator
Urbana Place Senior Living
5601 94th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35230015

Dear Administrator:

On August 24, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the March 16, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 9, 2022

Administrator
Urbana Place Senior Living
5601 94th Avenue North
Brooklyn Park, MN 55443

RE: Project Number SL35230015

Dear Administrator:

On June 1, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 16, 2022. The follow-up evaluation determined your facility had corrected all of the state licensing orders issued pursuant to the March 16, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 16, 2022, found not corrected at the time of the June 1, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $3,000.00

1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00

1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3 - $500.00

The details of the violations noted at the time of this follow-up evaluation completed on June 1, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES:

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

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

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: _____ B. WING _____	R 06/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35230015-1 On May 31, 2021, through June 1, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 16, 2022. At the time of the survey, there were 81 residents: 78 receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued. An immediate correction order was identified on May 31, 2022, issued for SL35230015-1, tag identification 1620. On June 1, 2022, the immediacy of correction order 1620 was removed, however non-compliance remained at a scope and level of G.	{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.	

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{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}		
{0 780} SS=D	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:	{0 780}		

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{0 780}	Continued From page 2 (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: No further action required.	{0 780}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}		

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

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{0 810}	Continued From page 4 by: No further action required.	{0 810}		
{01620} SS=G	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 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 observation, interview and record review, the licensee failed to complete a change of condition reassessment when a resident presented with new or changed symptom for one of one resident (R14) with record reviewed.	{01620}	An immediate correction order was identified on May 31, 2022, issued for SL35230015-1, tag identification 1620. On June 1, 2022, the immediacy of correction order 1620 was removed,	

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{01620}	Continued From page 5 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R14 admitted January 27, 2020. R14' s Service Addendum to the Assisted Living Contract dated April 21, 2022, indicated R14 received assistance for bathing, meal set up, dressing, grooming, wellness visit, COVID-19 screening, homemaking, laundry, behavior management, medication administration, escort assistance and toileting reminders. R14's Service Addendum to the Assisted Living Contract dated May 31, 2022, indicated R14 received assistance for bathing, meal set up, dressing, grooming, COVID-19 screening, behavior management, homemaking, laundry, medication assistance, escort assistance, toileting assist, catheter cares and specialized treatments. R14's record indicated R14 had a change of condition related to a fall with left hip fracture that required surgical repair on May 21, 2022. Resident Incident Report dated May 21, 2022, at 8:15 a.m., indicated R14 fell from bed and 911 was called as a result of pain on the left side, inability to bear weight and left hip displacement.	{01620}	however non-compliance remained at a scope and level of G.	

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{01620}	Continued From page 6 R14's progress note dated May 27, 2022, at 12:00 p.m., indicated R14 returned to licensee's facility with new medication orders, and a change of status with ambulation, toileting and skin care. R14 returned to the licensee's facility from the hospital on May 27, 2022, at approximately 1:00 p.m. R14's Hospital Discharge Summary dated May 27, 2022, indicated R14 should attempt to walk 30 minutes per day for at least ten minutes at a time, physical and occupational therapy orders are medically necessary, wound should not be submerged in bath and an application of light dressing may be applied to wound as needed, and foley catheter to remain in place for ten to 14 days. R14' s record lacked a full head to toe assessment including a physical and cognitive assessment based on change in condition of R14. Resident Incident Report dated May 29, 2022, at 6:45 am, indicated R14 fell from bed and staff contacted hospice for a smaller hospital bed and fall mat. R14 admitted to hospice on May 30, 2022. Post Fall Huddle dated May 31, 2022, at 10:00 a.m., indicated R14 fell next to bed. R14 was assisted off the floor with a mechanical lift and assessed for injury. On May 31, 2022, at approximately 11:27 a.m., the surveyor observed R14 in wheelchair heavily leaning to the right. R14's family member attempted to fix R14's posture.	{01620}		

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{01620}	Continued From page 7 On May 31, 2022, at 11:54 a.m., the surveyor observed R14's family member placing two pillows around the side of R14 in the wheelchair to correct R14's posture. On May 31, 2022, at 12:03 p.m., registered nurse (RN)-A stated staff had not completed R14's change of condition assessment. In addition, RN-A stated R14 was going to be placed in a transitional care unit (TCU) from the hospital however, the hospital was unable to find placement. On May 31, 2022, at 12:09 p.m., the surveyor and RN-A observed R14 in wheelchair with multiple pillows supporting R14's position in wheelchair. RN-A verified R14 would need a different wheelchair in order to meet R14's needs for wheelchair positioning. On May 31, 2022, at 12:36 p.m., RN-A stated they had updated the service plan on May 27, 2022, and provided R14 a wheelchair upon return to facility, however, RN-A did not complete the change of condition assessment. On May 31, 2022, at approximately 1:38 p.m., RN-A stated the licensee was unaware that R14's family signed R14 with hospice services until it occurred, as the licensee and family had discussed rehab prior. On May 31, 2022, at approximately 1:40 p.m., RN-A acknowledged that documentation did not indicate R14 had a nursing assessment completed as the record lacked assessment or progress note of assessment. The surveyor asked RN-A when R14 was assessed. RN-A stated on Friday May 27, 2022, between 1:00	{01620}		

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{01620}	Continued From page 8 p.m. and 1:30 p.m., as they had to complete an assessment in the community. In addition, RN-A stated they believed they had five days to complete a change of condition assessment, like an admission assessment. On May 31, 2022, at 4:05 p.m., unlicensed personnel (ULP)-M stated R14 has required increased assistance since hospital return. In addition, ULP-M stated R14 has needed more assistance with activities of daily living, mobility and has had an increase in restlessness and anxiety. On May 31, 2022, at 4:09 p.m., ULP-N stated since hospital return, R14 has needed increased assistance with toileting, changing, skin care, safety checks, ambulation, wheelchair, and "almost everything." In addition, ULP-N stated some of the information was updated this weekend on the licensee's tablets but not all. The licensee's Comprehensive Assessment Schedule policy, dated March 2021, indicated an Annual/Change of Condition Level of Care Tool would be completed as indicated and may be conducted in the residence or through use of telecommunication methods. TIME PERIOD FOR CORRECTION: Immediate On June 1, 2022, the immediacy of correction order 1620 was removed, however non-compliance remained at a scope and level of G. NEW TIME PERIOD FOR CORRECTION: Two (2) days	{01620}		

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{01650}	Continued From page 9	{01650}		
{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 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 the service plan contained all required content for one of one resident (R15) with record reviewed. This practice resulted in a level two violation (a	{01650}		

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{01650}	Continued From page 10 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: R15's diagnoses included dysthymic disorder (a chronic form of depression), osteoarthritis, adjustment disorder with mixed anxiety and depressed mood and chronic pain. R15's Service Addendum to the Assisted Living Contract dated April 27, 2022, indicated R15 received services including bathing, meal set-up, dressing assistance, compression stockings, nail care, medical monitoring, behavior management, laundry, skin care, medication management, escorts, transfer assist and toileting assistance. R15's service plan lacked methods of monitoring staff providing services. On June 1, 2022, at approximately 10:00 a.m., registered nurse (RN)-A verified R15, and all other resident service plans lacked methods of monitoring staff. RN-A stated they supervise the staff in person and watch them complete tasks. Regional clinical lead (RCL)-O stated the licensee would update service plans for this facility and other facilities under their company. On June 1, 2022, at approximately 11:29 a.m., (RCL)-O stated licensee had updated the service plans and printed them to have residents sign the updated version.	{01650}		

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URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01650}	Continued From page 11 The licensee's Service Plan Guidelines policy dated March 2021 indicated the licensee would include the frequency of sessions of supervision of staff and type of personnel who will supervise staff. No further information was provided.	{01650}		
{01940} SS=F	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; (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	{01940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01940}	Continued From page 12 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 interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R15) who received treatments with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R15's diagnoses included dysthymic disorder (a chronic form of depression), osteoarthritis, adjustment disorder with mixed anxiety and depressed mood and chronic pain. R15's Service Addendum to the Assisted Living Contract dated April 27, 2022, indicated R15 received services including bathing, meal set-up, dressing assistance, compression stockings, nail care, medical monitoring, behavior management, laundry, skin care, medication management, escorts, transfer assist and toileting assistance. R15's medication administration record (MAR) dated May 2022 included thrombo-embolus-deterrent (TED) stockings on in the morning off in the evening, nystatin 1 gram	{01940}		

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{01940}	Continued From page 13 (gm) to groin twice per day for rash, and triamcinolone 0.1 percent (%) twice per day to superficial wound and excoriation of the right posterior thigh. R15's record lacked a treatment management plan that included procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services. On June 1, 2022, at 10:15 a.m., regional clinical lead (RCL)-O verified R15's record lacked a treatment plan that included procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatments or therapy services. RCL-O stated the licensee updated residents blood pressures and blood glucoses with the information of when to call a nurse, however, did not know it applied to all treatments residents received. In addition, RCL-O stated staff would add when to notify a nurse to current treatments in the facility. On June 1, 2022, at 11:29 a.m., RCL-O stated staff had almost reviewed all residents' treatments in the facility to ensure they had when to contact a nurse if a problem arouse with a treatment. The licensee's Medications & Treatments policy dated August 2021 indicated the licensee would develop and maintain a current individualized treatment management plan based on resident assessment and would reflect required content noted above. No further information was provided.	{01940}		

Electronically Delivered

April 1, 2022

Administrator
Urbana Place Senior Living
5601 94th Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35230015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 16, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

REQUESTING A HEARING

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

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

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

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

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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: SL# 35230015 On, March 14, 2022, through March 16, 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 67 residents; 51 receiving 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	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 according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 Reports, dated March 14, 2022.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	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. (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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This practice had the potential to affect the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 3 The findings include: HAND HYGIENE On March 15, 2022, at approximately 7:25 a.m., the surveyor observed unlicensed personnel (ULP)-D, walk into resident room. ULP-D introduced herself but did not wash or sanitize her hands before giving cares. On March 15, 2022, at approximately 7:30 a.m., the surveyor attempted to use the hand sanitizing station by the entrance into the dining area in the memory care unit, but it was empty. On March 15, 2022, at approximately 7:35 a.m., the surveyor observed ULP-D provide a compression treatment to R3. On March 15, 2022, at 7:38 a.m., ULP-D removed gloves and without hand hygiene, started medication administration for R3. On March 15, 2022, at 7:40 a.m., ULP-D washed hands with resident's dish soap at the kitchen sink. On March 15, 2022, at approximately 7:42 a.m., ULP-D stated the licensee lacked easily accessible places for staff to perform hand hygiene and also stated residents sometimes get upset when staff use the resident's personal products. ULP-D did not carry a personal bottle of hand sanitizer. On March 15, 2022, at approximately 8:14 a.m., the surveyor observed ULP-D wash her hands with dish soap in R8's sink. On March 15, 2022, at approximately 12:15 p.m.,	0 510		

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0 510	Continued From page 4 RN-A stated the expectation is staff perform hand hygiene before and after cares. RN-A stated some of the resident's bathrooms contained soap dispensers, and if a resident's bathroom did not contain a soap dispenser, staff would need to use common area bathrooms for hand hygiene. In addition, RN-A stated the licensee provided ULPs a supply bag that contained hand sanitizer. On March 16, 2022, at approximately 7:52 a.m., the surveyor observed no sanitizer station on 3rd floor for staff, residents or visitors to use. On March 16, 2022, at approximately 7:58 a.m., the surveyor observed no sanitizer station or sanitizer bottles outside resident rooms on the 4th floor for staff, residents or visitors to use. On March 16, 2022, at approximately 8:25 a.m., the surveyor used the sink in the memory care near dining room, however, no soap was available to wash hands. On March 16, 2022, at approximately 8:27 a.m., ULP-B stated staff do not carry the supply bags provided by licensee due to them being too heavy. The licensee's Infection Prevention and Control Program policy, dated April 2020, indicated an infection preventionist or licensed nurse would develop and implement an infection control program to be up to date with Centers for Disease and Control Prevention (CDC) publications. The CDC When and How to Wash Your Hands dated March 14, 2022, indicated hand washing should be conducted before and after preparing food, before and after eating food, before and	0 510		

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0 510	Continued From page 5 after caring for someone at home who is sick with vomiting or diarrhea, before and after treating a cut or wound, after using the toilet, after blowing nose or coughing and after touching garbage. SHARPS CONTAINER On March 15, 2022, at approximately 8:37 a.m., the surveyor observed the sharps container in R7 room was filled over the do not fill line. On March 15, 2022, at approximately 12:15 p.m., RN-A stated staff should close full sharps containers and then place them into the biohazard bin. The licensee's Infection Prevention and Control Program policy, dated April 2020, indicated an infection preventionist or licensed nurse would develop and implement an infection control program to be up to date with Centers for Disease and Control Prevention (CDC) publications. The CDC Sharps Safety dated February 11, 2015, indicated not to overfill sharps containers. FOOD On March 15, 2022, at approximately 8:14 a.m., the surveyor observed ULP-D remove dinner contents from R8's bedside table, which had remained unrefrigerated from the day before. This posed a risk of food-borne illness to the resident. On March 15, 2022, at approximately 12:18 p.m., surveyor observed an approximately half-consumed water bottle on the side handrail in the memory care unit. This posed a risk to confused and wandering residents who may pick it up and drink from it, hence spreading germs.	0 510		

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0 510	Continued From page 6 On March 16, 2022, at approximately 8:02 a.m., in the memory care unit, the surveyor observed a common area refrigerator/freezer contained a three-gallon container of Dean's Country Fresh orange sherbet with an opened-on date hand-written in marker of "8/10" (August 10) and a stamped expiration date of June 17, 2020. Additionally, an undated half-consumed soda bottle, undated leftover unknown food in two containers, and four containers of undated opened pastries. This posed a risk of food-borne illness to the memory care residents. On March 16, 2022, at approximately 8:25 a.m., RN-A acknowledged the findings in the refrigerator and stated she would check with dining supervisor about the same. The licensee's policy Transportation of foods from Central Kitchens to Satellite Locations dated 2019 indicated ready-to-eat food may be stored up to seven days from the initial date of opening or by the use date, whichever comes first. EYEWEAR On March 15, 2022, at approximately 12:25 p.m., the surveyor observed unlicensed personnel (ULP)-B in the dining room serving residents with her protective eyewear worn below her nose, not covering her eyes. On March 16, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-K walk into a resident room with her mask below her nose, wearing prescription glasses without appropriate eye protection. On March 16, 2022, at approximately 7:40 a.m., when surveyor asked ULP-K about her eye	0 510		

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0 510	Continued From page 7 protection, ULP-K stated the face shield fog made vision difficult when working with residents. The licensee's Infection Prevention and Control Program policy, dated April 2020, indicated an infection preventionist or licensed nurse would develop and implement an infection control program to be up to date with Centers for Disease and Control Prevention (CDC) publications. The CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated February 2, 2022, indicated eye protection should be worn during all patient care encounters. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the 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.	0 630		

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0 630	Continued From page 8 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) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for 4 of 5 residents (R1, R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted for service on April 20, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's diagnoses include essential hypertension, unspecified osteoarthritis and depression. R1's Annual/Change in Condition Assessment dated February 21, 2022, included the following vulnerabilities: poor range of motion, forgetfulness, chronic condition or pain that restricts physical activity, environmental safety. R1's plan failed to include statements of the specific measures to be taken to minimize the risk of abuse. R2 R2 admitted for service on April 2, 2021, under	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

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0 630	Continued From page 9 the comprehensive home care license and began receiving assisted living services on August 1, 2021. R2's diagnoses include type II diabetes, coronary artery disease and paranoid schizophrenia. R2's Annual/Change in Condition Assessment dated November 12, 2021, included the following vulnerabilities: managing finance, social support system, abuse alcohol or substances, impaired judgment, and chronic condition or pain that restricts physical activity. R2's plan failed to include statements of the specific measures to be taken to minimize the risk of abuse. R3 R3 admitted for service on February 2, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's diagnoses include chronic kidney disease 3, adjustment disorder with mixed anxiety and depressed mood, hypertension (HTN) and osteoarthritis. R3's Annual/Change in Condition Assessment dated August 31, 2021, included the following vulnerabilities: poor strength or endurance for physical activity, inability to manage finances, impaired judgement due to mental health issues and is vulnerable for abuse by others. R3's abuse prevention plan failed to include statement of specific measure to be taken to minimize the risk of abuse. R4 R4 admitted for service on April 10, 2021, under the comprehensive home care license and began	0 630		

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0 630	Continued From page 10 receiving assisted living services on August 1, 2021. R4's diagnoses include type II diabetes and dementia without behavioral disturbance. R4's Annual/Change in Condition Assessment dated April 15, 2021, included the following vulnerabilities: confusion, ambulation, lack of accuracy in information provided, poor range of motion, managing finances, not able to report abuse, environmental safety, and chronic condition restricting activity. R4's plan failed to include statements of the specific measures to be taken to minimize the risk of abuse. On March 16, 2022, at approximately 12:20 p.m., registered nurse (RN)-A acknowledged R1, R2, R3 and R4's vulnerability assessment and prevention plans lacked statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. In addition, RN-A stated the licensee would update all the residents IAPPs to meet the statute requirement. The licensee's Individual Abuse Prevention Plan policy, dated July 2021, indicated the licensee would develop an IAPP for every resident and the plan would include the evaluation of statements of the specific measures to be taken to minimize the risk of abuse to the residents and other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 680	Continued From page 11	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency disaster plan with all required content and post an emergency disaster plan prominently. In addition, the licensee failed to provide the minimum frequency of inspection, maintenance and load test requirements for the emergency power generator as outlined under NFPA 110,	0 680		

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0 680	Continued From page 12 (referenced under the Code of Federal Regulations, title 42, section 483.73). This had the potential to affect all 67 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on March 14, 2021, at approximately 9:45 a.m., the surveyor requested to view the licensee's emergency preparedness plan. On March 14, 2022, at approximately 10:47 a.m., during a tour of the facility, the surveyor noted the emergency exit diagrams were not posted on any of the facility floors where the residents resided. The licensee's emergency disaster preparedness plan lacked the following required content: - development of emergency preparedness (EP) policies and procedures; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering; - policies and procedures for medical documents; - policies and procedures for volunteers; - long term care (LTC) family notifications; - LTC emergency power; - emergency prep training and testing; and - integrated health systems.	0 680		

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0 680	Continued From page 13 Document review of weekly inspection records for the generator systems indicated the last recorded inspections on the "Preventative Maintenance Checklist" were dated October 18, 2021, and March 14, 2021. Document review of monthly generator load test records indicated the last recorded tests on the "Preventative Maintenance Checklist" were dated October 18, 2021, and March 14, 2021. Document review of monthly transfer switch operation test records indicated the last recorded monthly transfer switch tests on the "Preventative Maintenance Checklist" were dated October 18, 2021, and March 14, 2021. On March 14, 2022, at approximately 4:30 p.m., licensed assisted living director (LALD)-C acknowledged the findings and stated that licensee would try to obtain additional records from their contracted company for the generator. Survey staff agreed to receive additional records for review through the end of day on March 15, 2022. The surveyor received additional information from LALD-C via email on March 15, 2022, at 8:38 a.m., which stated after further review, the licensee did not find additional documentation regarding the generator load testing monthly. On March 14, 2022, at approximately 4:20 p.m., LALD-C acknowledged the licensee's emergency disaster preparedness plan lacked required content as noted above. The licensee's Assisted Living Disaster and Emergency Plan policy dated August 2021 indicated the licensee's emergency plan would	0 680		

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0 680	Continued From page 14 include required elements of appendix Z, but lacked verbiage for frequency of inspection, maintenance, and load test requirements for the emergency power generator. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	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	0 780		

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0 780	Continued From page 15 by: Based on observation and interview, the licensee failed to maintain proper functioning of the smoke alarm in resident room #2 of the memory care unit as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect all assisted living residents, visitors, and staff. 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: On March 14, 2022, survey staff toured the facility with the director of maintenance (DOM)-L between the hours of 11:45 a.m. to 3:00 p.m. The licensed assisted living director (LALD)-C joined the tour approximately between the hours of 12:40 p.m. to 1:40 p.m. On March 14, 2022, at approximately 1:45 p.m., while on tour survey staff observed the smoke alarm in memory care room #2 did not alarm when tested. Further investigation by the DOM-L, the smoke alarm was not connected (wired) and when opened up, the alarm unit was also missing batteries. On March 14, 2022, at approximately 4:15 p.m., the DOM-L and the LALD-C acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		

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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 record review, observation, and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. 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 14, 2022, survey staff toured the facility with the director of maintenance (DOM)-L between the hours of 11:45 a.m. to 3:00 p.m. The licensed assisted living director (LALD)-C joined the tour approximately between the hours of 12:40 p.m. to 1:40 p.m. On March 14, 2022, at approximately 3:00 p.m., survey staff received documentation from the LALD-C relating to the facility's fire alarm and the fire sprinkler system, letters issued by the	0 800		

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0 800	Continued From page 17 Brooklyn Park Fire, dated February 9, 2022. FIRE ALARM and FIRE SPRINKLER SYSTEM -Document review of the overdue notification letter from the City of Brooklyn Park Fire Department, dated February 9, 2022, required the licensee to take action to inspect, test, and maintain the fire alarm system by a licensed company. -Document review of the overdue notification letter from the City of Brooklyn Park Fire Department, dated February 9, 2022, required the licensee to take action to inspect, test, and maintain the fire sprinkler system by a licensed company. The letters required the licensee to inspect, test, and maintain the building fire alarm and the fire sprinkler alarm systems. BACKFLOW PREVENTER TESTS The backflow preventer serving the lawn irrigation system (pressure type vacuum breaker) and the backflow preventer located in the main trash room (reduced pressure zone assembly) indicated last tested on July 15, 2019. Backflow preventers must be maintained and tested annually to protect the potable water supply by a qualified backflow tester. On March 14, 2022, at approximately 4:15 p.m., the DOM-L and the LALD-C acknowledged the above findings at the exit interview. The LALD-C explained that she had arranged for a contractor to be onsite to test and inspect the fire alarm and fire sprinkler system. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide all	0 810		

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0 810	Continued From page 19 required content on the fire safety and evacuation plan, evacuation drills, and the required training of staff on fire safety and evacuation. This has the potential to directly affect the safety of staff and all residents receiving care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On March 14, 2022, survey staff received the facility fire safety and evacuation plan and related documentation for review. The findings include: FIRE SAFETY AND EVACUATION PLAN The building layout plan lacked the identification of sleeping locations and the number of sleeping rooms. TRAINING Documentation review indicated the Relias Annual Education Schedule 2021, and policy (undated), Training and Drills, indicated employee training on fire safety and evacuation upon hire and annually, thereafter. Employee training must be provided upon hire and twice a year, thereafter, to meet minimum requirements. FIRE and EVACUATION DRILLS -Policy documentation review of the policy (undated), Training and Drills, indicated fire drills were to be performed quarterly or more frequent if required by the local and/or state. Evacuation	0 810		

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0 810	Continued From page 20 drills must be performed at least twice per year per shift, with at least one evacuation drill every other month. Fire drills and evacuation drills may be combined when conducting drills. -Drill record review showed an insufficient number of evacuation drills performed. The records indicated the last drills performed were dated October 7, 2021 (second shift) and January 18, 2022 (first shift). On March 14, 2022, at approximately 4:30 p.m., the DOM-L and the LALD-C acknowledged the above findings at the exit interview. Survey staff explained that all records of training and evacuation drills must be kept to show the minimum frequencies to substantiate requirements have been met. Additional information was provided by the LALD-C on 1) March 15, 2022, at 11:19 a.m., regarding employee training provided during the past year on 144G Education (Due August 31, 2021), and 2) March 15, 2022, at 8:38 a.m., regarding an additional fire drill performed and recorded, dated October 7, 2021 at 4:02 p.m. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is	0 970		

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0 970	Continued From page 21 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 facility's liability for health, safety, or personal property of a resident for five of five residents (R1, R2, R3, R4, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted for service on April 20, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's Assisted Living Contract was signed August 1, 2021. R1's Assisted Living Contract, page 16, sections 2 and 4, indicated the resident would waive the facility's liability for injury, death or property damage occurring in the apartment unit or on the providers premises. R2 R2 admitted for service on April 2, 2021, under the comprehensive home care license and began	0 970		

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URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

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0 970	Continued From page 22 receiving assisted living services on August 1, 2021. R2's Assisted Living Contract was signed August 1, 2021. R2's Assisted Living Contract, page 16, sections 2 and 4, indicated the resident would waive the facility's liability for injury, death or property damage occurring in the apartment unit or on the providers premises. R3 R3 admitted for service on February 2, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's Assisted Living Contract was signed August 1, 2021. R3's Assisted Living Contract, page 16, sections 2 and 4, indicated the resident would waive the facility's liability for injury, death or property damage occurring in the apartment unit or on the providers premises. R4 R4 admitted for service on April 10, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R4's Assisted Living Contract was signed August 1, 2021. R4's Assisted Living Contract, page 16, sections 2 and 4, indicated the resident would waive the facility's liability for injury, death or property damage occurring in the apartment unit or on the	0 970		

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	35230	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

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0 970	Continued From page 23 providers premises. R5 R5 admitted for assisted living services on January 17, 2022. R5's Assisted Living Contract was signed December 22, 2021. R5's Assisted Living Contract, page 16, sections 2 and 4, indicated the resident would waive the facility's liability for injury, death or property damage occurring in the apartment unit or on the providers premises. On March 14, 2022, at approximately 2:10 p.m., the LALD-A acknowledged the licensee's contract contained a waiver of liability and stated licensee would look at the section. In addition, LALD-A stated the same contract was used for all residents in the facility. The licensee lacked and Assisted Living Contract policy. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01620 SS=F	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	01620		

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01620	Continued From page 24 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 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 14-day reassessment for one of five residents (R5) and ongoing resident reassessment to include all areas required on the uniform assessment tool for three of three residents (R3, R4, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01620		

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01620	Continued From page 25 14-DAY ASSESSMENT R5 R5's Service Addendum to the Assisted Living Contract dated January 20, 2022, indicated R5 received services for wellness visits, elopement prevention, medication administration including injections and diabetic management. R5's record indicated the RN completed an admission assessment on January 20, 2022 and a 14-day assessment on March 4, 2022. R5 record lacked any further assessments. At the time of the survey, R5's assessment was twenty-nine (29) days past due. On March 16, 2022, at approximately 9:55 a.m., registered nurse (RN)-A confirmed R5's record only contained the two assessments listed above. RN-A stated R5 had moved from assisted living to the memory care unit shortly after admission which caused timing issues with the assessments. ONGOING ASSESSMENTS R3 R3's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R3 received services for bathing, compression stockings, medical monitoring and medication administration. R3's record included a 90-day reassessment titled Comprehensive Assessment dated December 13, 2021. R4 R4's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R4 received services for bathing, dressing, covid	01620		

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01620	Continued From page 26 screening, wellness visit, laundry, homemaking, medication administration, blood glucose moitoring, toileting, nail care and escort assist. R4's record included a 90-day reassessments titled Comprehensive Assessment dated November 3, 2021, and February 1, 2022. R5 R5's Service Addendum to the Assisted Living Contract dated January 20, 2022, indicated R5 received services for wellness visits, elopement prevention, medication administration including injections, and diabetic management. R5's record included a 14-day reassessment titled Comprehensive Assessment dated March 4, 2022. R3, R4, and R5 comprehensive reassessments lacked the following areas required on the uniform assessment tool: - the residents personal lifestyle preferences; - instrumental activities of daily living; - physical health status; - communication and sensory capabilities; - pain; - skin conditions; - nutritional and hydration status preferences; - list of treatments; and - risk indicators. On March 16, 2022, at approximately 11:25 a.m., RN-A and RN-G acknowledged the licensee's assessment missed sections of the uniform assessment tool and stated the same form was used for all of the licensee's residents. In addition, RN-A and RN-G stated the licensee was in the process of updating their forms to reflect all the sections of the uniform assessment tool.	01620		

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01620	Continued From page 27 The licensee's Comprehensive Assessment Schedule policy, dated March 21, indicated a RN would complete a Comprehensive Review within 14 days after initiation of services and at least every 90 days thereafter. The licensee's policy lacked verbiage for ongoing assessments to require all areas on the uniform assessment tool. 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 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;	01650		

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01650	Continued From page 28 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 the service plan contained all the required content for five of five residents (R1, R2, R3, R4, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses include essential hypertension, unspecified osteoarthritis and depression. R1's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R1 received services including bathing, dressing, okay checks, Covid screening, wellness visit, laundry, medication assist/administration and escort. R2 R2's diagnoses include type II diabetes, coronary	01650		

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01650	Continued From page 29 artery disease and paranoid schizophrenia. R2's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R2 received services including bathing, dressing, compression stockings, grooming, wellness visit, laundry, escort, nail care, medication assist/administration, insulin administration and blood glucose monitoring. R3 R3's diagnoses include chronic kidney disease 3, adjustment disorder with mixed anxiety and depressed mood, hypertension (HTN), and osteoarthritis. R3's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R3 received services for bathing, compression stockings, medical monitoring and medication administration. R4 R4's diagnoses include type II diabetes, and dementia without behavioral disturbance. R4's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R4 received services including bathing, dressing, covid screening, homemaking/bedmaking, toileting/incontinence assist, laundry, medication assist/administration and blood glucose monitoring. R5 R5's diagnoses include type 2 diabetes, glaucoma, hypertension (HTN) and dementia without behavioral disturbance. R5's Service Addendum to the Assisted Living	01650		

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01650	Continued From page 30 Contract dated January 20, 2022, indicated R5 received services for wellness visits, elopement prevention, medication administration including injections and diabetic management. R1, R2, R3, R4, and R5's service plans lacked the following content: - methods of monitoring staff providing services. In addition R5's service plan lacked: - declarations made by the resident in which emergency medical services would not to be summoned consistent with chapters 145B. On March 15, 2022, at approximately 12:15 p.m., registered nurse (RN)-A acknowledged all service plans lacked methods of monitoring staff. In addition, RN-A also acknowledged R5's record lacked declarations made by the resident in which emergency medical services would not to be summoned. The licensee's Service Plan Guidelines, dated March 2021, indicated the service plan would contain declarations made by the resident in which emergency medical services are not to be summoned and schedule of monitoring staff providing services however, lacked methods of monitoring staff providing services, and monitoring resident assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted	01760		

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01760	Continued From page 31 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 observation, interview and record review, the licensee failed to ensure medication was administered as prescribed for one of six residents (R8) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R8 admitted for service on March 3, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R8's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R8	01760		

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01760	Continued From page 32 received services for bathing, dressing, grooming, wellness visits, laundry, transfer assistance, escort assistance, toileting assistance and medication management. R8's provider orders dated February 27, 2022, included the following medications: Tylenol 1000 milligrams (mg) three times per day, amlodipine 10 mg one time per day, diclofenac sodium 1 percent (%) gel apply 2 grams (g) to right knee four times per day, ditiazem extended release (er) 60 mg twice per day, loratadine 10 mg daily and metoprolol succinate er 150 mg two times per day. On March 15, 2022, at approximately 8:17 a.m., the surveyor observed unlicensed personnel (ULP)-D apply diclofenac sodium 1% to bilateral knees without measurement of medication. On March 16, 2022, at approximately 10:43 a.m., registered nurse (RN)-A stated diclofenac gel should be placed on a card for dosing and then applied to the resident. RN-A acknowledged ULP's administration of diclofenac gel lacked dosing of medication. RN-A stated cards for dosing come with medication, however, are misplaced easily. The licensee's Medications & Treatments policy, dated August 2021, indicated staff were to read and compare the label of medication to the information on the medication administration record (MAR) three times using the six right of medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

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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's recommended temperatures when they did not monitor or document medication refrigerator temperatures located in the clinical office. 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 14, 2022, at approximately 10:32 a.m., the surveyors observed medication refrigerator in the clinical office. The medication refrigerator lacked a thermometer and no temperature log for medication refrigerator was observed. The medication refrigerator contained the following medications: - three (3) doses of Shingrix 50/0.5 milliliter (ml) for R-11, R12, R13 and R15; - one (1) vial of cyanocobalamin 100 micrograms (mcg) for R14;	01880		

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01880	Continued From page 34 - one (1) bisacodyl 10 mg suppository for R16; - one (1) fluzone injection 0.7 ml for R17; - one (1) aplisol injection 5/0.1 ml for R13; - Tuberculin PPD injection 5 unit/0.1 ml for R13; and - Pneumovax-23 injection 25 mcg/0.5 ml. On March 14, 2022, at approximately 10:41 a.m., licensed assisted living director (LALD)-C stated the licensee lacked a refrigerator temperature log for the medication refrigerator. LALD-C also stated some of the items in the refrigerator were pending destruction by registered nurse (RN). The licensee's Medications & Treatment policy, dated August 2021 indicated medications would be stored consistent with manufacturer's recommendations including refrigerated medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to discard expired medication for eight of	01890		

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01890	Continued From page 35 eight residents (R3, R4, R7, R8, R10, R12, R13, R15) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 R3's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R3 received services for bathing, compression stockings, medical monitoring and medication administration. R3's provider orders dated April 29, 2021, included the following medications: acetaminophen 1000 milligrams (mg), lisinopril 40 mg, lorazepam 0.5mg, meloxicam 15mg, omeprazole 20 mg, nystatin 100000 units, and tolterodine 1 mg. On March 15, 2022, at approximately 7:30 a.m., the surveyor observed R3's locked medication cabinet which contained three (3) expired medications to include: - nystatin 100,000 units/gram bottle with expiration date of October 21, 2021; - acetaminophen 500 mg bubble pack which contained 2 tablets per bubble with expiration date of January 28, 2022; and - acetaminophen 500 mg bubble pack which contained 2 tablets per bubble with expiration date of January 8, 2022.	01890		

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01890	Continued From page 36 R4 R4's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R4 received services including bathing, dressing, covid screening, homemaking/bedmaking, toileting/incontinence assist, laundry, medication assist/administration and blood glucose monitoring. R4's provider orders dated June 7, 2021, indicated R4 received the following medications: acetaminophen 325 mg tablet taken two tablets orally three times daily, amlodipine 5 mg tablet by mouth daily, aspirin 81 mg by mouth daily, losartan potassium 25 mg by mouth daily, metformin 500 mg tablet twice a day, pantoprazole 40 mg tablet by mouth daily, and Systane solution every one (1) hour as needed for dry eyes. On March 15, 2022, at approximately 9:26 a.m., the surveyor observed R4's locked medication cabinet which contained three (2) expired medications which included: - Systane solution with expiration date of January 26, 2022; and - Equaline anti itch ointment with expiration date of August 2020. R7 R7's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R7 received services for bathing, medication administration, blood glucose monitoring and wellness visits. R7's provider orders dated February 25, 2022, included the following medications: propranolol 20 mg, metformin extended release (er) 500 mg,	01890		

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	35230	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01890	Continued From page 37 Lantus 2 units, Tylenol 1000mg, tradjenta 5mg, olanzapine 5 mg, aspirin 81 mg, loperamide 2mg dextromethorphan-guaifenesin 10 mg-100 mg/5 milliliter (ml) oral syrup to take 10 ml. On March 15, 2022, at approximately 8:37 a.m., the surveyor observed R7's locked medication cabinet which contained three (5) expired medications to include: - triamcinolone acetonide ointment 0.0025 percent (%) with expiration date of June 2020; - Magic Butt Paste with expiration date of December 25, 2020; - loperamide 2 mg capsules with expiration date of January 7, 2022; - aspirin 81 mg chewable tab with expiration date of August 2021; and - dextromethorphan suspension 30mg/ 5 ml with expiration date of January 4, 2022. R8 R8's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R8 received services for bathing, dressing, grooming, wellness visits, laundry, transfer assistance, escort assistance, toileting assistance and medication management. R8's provider orders dated February 27, 2022, included the following medications: Tylenol 1000 mg three times per day, amlodipine 10 mg one time per day, diclofenac sodium 1 % gel apply 2 grams (g) to right knee four times per day, diltiazem er 60 mg twice per day, loratadine 10 mg daily, and metoprolol succinate er 150 mg two times per day. On March 15, 2022, at approximately 8:14 a.m., the surveyor observed R8's locked medication cabinet which contained one (1) expired	01890		

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01890	Continued From page 38 medication which included: - tizanidine 2 mg with expiration date of March 10, 2022. R10 R10's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R10 was receiving services to include medication administration. R10's provider orders dated December 9, 2021, indicated R10 received the following medications: glimepiride one mg tablet by mouth daily, polyethylene glycol 17 mg packet orally daily as needed, sertraline 50 mg tablet orally daily, and rivaroxaban 15 mg tablet twice daily with breakfast and dinner. On March 15, 2022, at approximately 10:26 a.m., the surveyor observed R10's locked medication cabinet which contained three (2) expired medications to include: - Laxa clear (polyethylene glycol 3350) with an expiration date of June 2020; and - Vision formula 50+ supplement with an expiration date of March 2020. MEDICATION REFRIGERATOR On March 14, 2022, at approximately 10:32 a.m., the surveyors observed three (3) expired medications in the medication refrigerator located in the clinical office to include: - Shingrix injection 50/0.5ml one vial with expiration date of February 7, 2022, for R15; - Shingrix injection 50/0.5ml one vial with expiration date of February 7, 2022, for R12; and - Shingrix injection 50/0.5ml one vial with expiration date of February 7, 2022, for R13. On March 15, 2022, at approximately 7:42 a.m.,	01890		

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01890	Continued From page 39 unlicensed personnel (ULP)-D stated when administering medication, ULP's look at the expiration dates. If medication(s) being administered are expired, ULP's will notify nurses to dispose. On March 15, 2022, at approximately 11:10 a.m., RN-A stated nursing staff check medication cabinets every 30 days to remove expired medications. On March 15, 2022, at approximately 12:15 p.m., registered nurse (RN)-A acknowledged expired medications in resident rooms as listed above. RN-A stated nurses are to look for expired medication and dispose of them with each wellness visit or when delivering medications to rooms. The licensee's Medications & Treatments policy, dated August 2021, indicated expired medications would be disposed of according to the accepted practices of the Minnesota Board of Pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	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	01940		

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01940	Continued From page 40 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; (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 a treatment management plan to include all required content for four of five residents (R1, R2, R4, R5) who received treatments with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01940		

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01940	Continued From page 41 The findings include: R1 R1's diagnoses included essential hypertension, unspecified osteoarthritis, depression, heart failure (HF) and unspecified HF chronicity. R1's Discharge Orders signed and dated February 19, 2022, indicated R1 received continuous home oxygen therapy at one liter per nasal cannula. R1's record lacked a treatment management plan to include: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2 R2's diagnoses included type II diabetes, coronary artery disease and paranoid schizophrenia. R2's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R2	01940		

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01940	Continued From page 42 received services including compression stockings, medication administration, insulin administration and blood glucose monitoring. R2's discharge information electronically signed and dated October 7, 2021, indicated R2 received blood glucose monitoring due to type II diabetes mellitus with complications, compression men's hose put on every morning and removed at bedtime. R2's record lacked a treatment management plan to include: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. R4 R4's diagnoses included type II diabetes and dementia without behavioral disturbance. R4's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R4 received services including bathing, dressing, covid screening, homemaking/bedmaking, toileting/incontinence assist, laundry, medication assist/administration and blood glucose monitoring. On March 15, 2022, at approximately 8:10 a.m., the surveyor observed ULP-B check R2's blood glucose and record it as 259 milligrams per	01940		

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01940	Continued From page 43 deciliter (mg/dl). R4's record lacked a treatment management plan to include: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. R5 R5's diagnoses include type II diabetes, glaucoma, hypertension (HTN) and dementia without behavioral disturbance. R5's Service Addendum to the Assisted Living Contract dated January 20, 2022, indicated R5 received services for wellness visits, elopement prevention, medication administration including injections and diabetic management. R5's General Admission Orders dated December 21, 2022, indicated R5 received blood glucose monitoring due to type II diabetes. R5's record lacked a treatment plan that included: - any resident-specific requirements relating to documentation of treatment and therapy received and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On March 16, 2022, at approximately 10:43 a.m., registered nurse (RN)-A stated parameters for when to contact provider regarding resident's	01940		

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01940	Continued From page 44 blood glucose are located on the electronic medication administration record (EMAR), however RN-A acknowledged R5's record did not include parameters on when to contact provider for blood glucose levels. On March 16, 2022, at approximately 11:50 a.m., RN-A acknowledged the resident records lacked treatment management plans. In addition, RN-A stated the licensee was in the process of updating the assessment form to include treatment management plans with all required information. The licensee's Medications and Treatments policy dated August 2021 indicated the licensee would develop and maintain a current individualized treatment management plan based on resident assessment and would reflect required content noted above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
02090 SS=F	144G.82 Subdivision 1 General The licensee of an assisted living facility with dementia care is responsible for the care and housing of the persons with dementia and the provision of person-centered care that promotes each resident's dignity, independence, and comfort. This includes the supervision, training, and overall conduct of the staff. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	02090		

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02090	Continued From page 45 failed to maintain a dignified dining experience for three of three residents (R18, R19, R20) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, at approximately 8:10 a.m., the surveyor observed the memory care unit during breakfast. Staff did not remain in the dining room to supervise or respond to resident needs as needed. Rather, staff would serve one resident at a time and either return to the kitchen area, which was behind a solid door, or exit the dining room to provide resident care in other areas. On March 15, 2022, at approximately 12:20 p.m., the surveyor observed R18 wander away from the table and did not eat the soup served. Staff did not reapproach resident to eat. On March 15, 2022, at approximately 12:30 p.m., R20 waited approximately 10 minutes to receive meal despite other residents around her having been served. When meal arrived, R20 complained of cold food. Surveyor interviewed R20 and R20 stated her food was often served cold. On March 15, 2022, at approximately 12:40 p.m., the surveyor observed one of three residents eating their meal in the center table of the dining	02090		

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02090	Continued From page 46	02090		

room, while the other two residents at the table had not been served their meal. Staff continued to serve other residents at different tables prior to serving the two residents at the center table.

On March 15, 2022, at approximately 12:41 p.m., the surveyor observed R19 with nectar thick liquids. Staff were not present to supervise resident while eating altered diet. This posed a risk of choking due to resident's special dietary needs.

On March 16, 2022, at approximately 8:00 a.m. to 9:00 a.m., surveyor observed memory care unit's dining room during breakfast. Residents were served then the staff either returned into the kitchen or went to provide cares to other residents. Staff were unavailable in the dining room to supervise and respond to resident's needs as needed.

On March 16, 2022, at approximately 8:55 a.m., culinary director (CD)-J acknowledged at least one unlicensed personnel (ULP) was supposed to remain present in dining room at all times to supervise residents during meals. CD-J also stated all food temperatures are checked in the kitchen upstairs and again when food arrives in the kitchen in memory care.

The licensee's policy for menu posting was requested but was not provided.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

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02110	Continued From page 47	02110		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.	02110		

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02110	Continued From page 48 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and/or the resident's legal and designated representatives at the time of move-in for five of five residents (R1, R2, R3, R4, R5) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings included: R1 R1 admitted for service on April 20, 2020, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R1 received services including bathing, dressing, okay checks, Covid screening, wellness visit, laundry, medication assist/administration and escort. R2 R2 admitted for service on April 2, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.	02110		

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02110	Continued From page 49 R2's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R2 received services including bathing, dressing, compression stockings, grooming, wellness visit, laundry, escort, nail care, medication assist/administration, insulin administration and blood glucose monitoring. R3 R3 admitted for service on February 2, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R3's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R3 received services for bathing, compression stockings, medical monitoring and medication administration. R4 R4 admitted for service on April 10, 2021, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R4's Service Addendum to the Assisted Living Contract dated August 25, 2021, indicated R4 received services including bathing, dressing, covid screening, homemaking/bedmaking, toileting/incontinence assist, laundry, medication assist/administration, and blood glucose monitoring. R5 R5 admitted for assisted living services on January 17, 2022. R5's Service Addendum to the Assisted Living Contract dated January 20, 2022, indicated R5	02110		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02110	Continued From page 50 received services for wellness visits, elopement prevention, medication administration including injections, and diabetic management. R1, R2, R3, R4 and R5's records all lacked evidence the resident and/or the resident's legal designated representative received the following required dementia care policies and procedures at the time of move-in: - philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities are implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On March 15, 2022, at approximately 10:55 a.m., licensed assisted living director (LALD)-C stated resident's records lacked acknowledgment that resident and/or family received the required	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35230	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
URBANA PLACE SENIOR LIVING	5601 94TH AVENUE NORTH BROOKLYN PARK, MN 55443

(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
02110	Continued From page 51 policies and procedures if they had moved in prior to the assisted living licensure. In addition, LALD-C stated the licensee had recently added an acknowledgment of policies received into a new form given to residents at the time of admission. The licensee lacked a policy for providing residents or designated representatives assisted living with dementia policies and procedures. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *03/14/22*
Time: 14:23:21
Report: 1023221060

Food and Beverage Establishment Inspection Report

Location:
Urbana Place Senior Living
5601 94th Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0038141
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634029190
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.

3-200A Food Characteristics: approved source

3-201.11A ** Priority 1 **

MN Rule 4626.0130A Remove all foods not obtained from approved sources from the premises.

OBSERVED FOODS OF UNKNOWN ORIGIN STORED IN WALK IN COOLER AND MEMORY CARE REACH IN COOLER SUCH AS YOGURT IN MASON JAR, LARGE SHERBERT TUB, LEFTOVERS IN TUPPERWARE, AND MUFFINS. INSTRUCTED OPERATOR TO DISCARD THESE ITEMS. SEE MORE DETAILS IN COMMENTS.

Comply By: 03/14/22

3-800 Highly Susceptible Populations

3-801.11C ** Priority 1 **

MN Rule 4626.0447C Discontinue serving raw or partially cooked animal foods or sprouts to a highly susceptible population.

OPERATOR STATED UNDERCOOKED ITEMS SUCH AS BURGERS WERE AVAILABLE TO ORDER. DISCONTINUE THIS PRACTICE AND ALWAYS COOK FOODS COMPLETELY.

Comply By: 03/14/22

3-500C Microbial Control: date marking

3-501.17A ** Priority 2 **

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

FROZEN TCS FOODS SAVED AS LEFTOVERS MARKED WITH DATE OF PREPARATION BUT FACILITY WAS NOT MARKING FREEZE DATES NOR THAW DATES. INSTRUCTED OPERATOR TO MARK FREEZE/THAW DATES TO ACCURATELY TRACK 7 DAYS UNDER REFRIGERATION.

Comply By: 03/14/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

OBSERVED PLASTIC TABLE USED FOR FOOD AND EQUIPMENT STORAGE. REPLACE TABLE WITH APPROVED COMMERCIAL GRADE PREP TABLE, SHELVING, OR DUNNAGE RACK.

Comply By: 03/14/22

4-900 Protecting Clean Items

4-903.11D

MN Rule 4626.0955D Discontinue storing items in open packages less than 6 inches above the floor on dollies, pallets, racks, and skids.

OBSERVED FOOD AND EQUIPMENT STORED ON MILK CRATES AND BREAD PALLETS. REPLACE THIS EQUIPMENT WITH APPROVED SHELVES AND DUNNAGE RACKS SO THAT FOOD IS STORED SAFELY.

Comply By: 03/14/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3 COMP DISPENSER
Violation Issued: No

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

Food and Equipment Temperatures

Process/Item: Cold Hold/CUT TOMATO
Temperature: 38 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

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

Process/Item: Cold Hold/GRAVY
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/TURKEY ROAST
Temperature: 40 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Freezer/ALL ITEMS
Temperature: FROZEN Degrees Fahrenheit - Location: WALK IN FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYORS FROM HRD WERE ASHLEY CREWS, BENARD NYANGENA, AND CASEY DEVRIES.

INSPECTION CONDUCTED IN PRESENCE OF KENG YANG, THE PERSON IN CHARGE OF THE KITCHEN. ALL VIOLATIONS WERE DISCUSSED WITH PERSON IN CHARGE AND HRD EVALUATORS DURING INSPECTION.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS.

COOLERS MAINTAINED BY FACILITY ARE NOT FOR PERSONAL USE OR PERSONAL FOOD. FOOD PROVIDED BY FACILITY MUST BE CLEARLY LABELED WITH THE NAME OF THE FOOD AS WELL AS THE DATE OF PREPARATION OR THE DATE IT WAS OPENED FOR COMMERCIALLY PRODUCED PRODUCTS.

THESE ADDITIONAL TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FOOD COOLING METHODS
- FOOD REHEATING METHODS
- COOKING A ROAST
- CATERING PROCEDURES
- SERVING HIGH RISK POPULATIONS

DOCUMENTS ON THE FOLLOWING TOPICS WERE INCLUDED WITH INSPECTION REPORT:
- EMPLOYEE ILLNESS TRACKING
- SAMPLE VOMIT CLEAN UP PROCEDURE
- SAMPLE HANDWASHING SIGN
- FOOD COOLING VERIFICATION
- FOOD REHEATING VERIFICATION
- CATERING SAFELY
- HIGH RISK POPULATION REQUIREMENTS

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023221060 of 03/14/22.

Certified Food Protection Manager: KENG YANG

Certification Number: 107088 Expires: 07/21/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

KENG YANG
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us