DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 13, 2023

Licensee
Meadows On Fairview Al
25565 Fairview Avenue
Wyoming, MN 55092

RE: Project Number(s) SL30338015

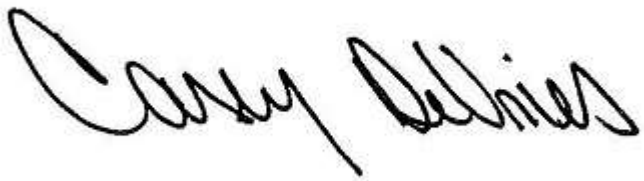
Dear Licensee:

On April 3, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the January 11, 2023, 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
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-281-9796

PMB

Electronically Delivered

February 2, 2023

Licensee
Meadows On Fairview AL
25565 Fairview Avenue
Wyoming, MN 55092

RE: Project Number(s) SL30338015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 11, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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
	30338	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have 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: SL30338015-0 On January 9, 2023, through January 11, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders were issued. At the time of the survey, there were 49 residents receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on January 10, 2023, issued for SL30338015-0, tag identification 2070. On January 10, 2023, the immediacy of correction order 2070 was removed. The scope and level remain unchanged. An immediate correction order was identified on January 10, 2023, issued for SL30338015-0, tag identification 2310.	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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0 000	Continued From page 1 On January 12, 2023, the immediacy of correction order 2310 was removed. The scope and level remain unchanged.	0 000		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 470		

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0 470	Continued From page 2 licensee failed to ensure the required staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels as required. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents The findings include: The licensee held an assisted living facility licensed for a capacity of 87 residents and had a current census of 49 residents. During entrance conference on January 9, 2023, at 10:51 a.m., licensed assisted living director (LALD)-A stated LALD-A and clinical nurse supervisor (CNS)-C were responsible for developing and reviewing the staffing plan at a minimal of twice a year. On January 10, 2023, at 8:52 a.m., LALD-A provided the evaluator with the licensee's staffing plan which lacked a date and signature by the CNS. LALD-A confirmed the licensee had not previously developed or implemented a staffing plan that determined staffing hours based on resident care needs that was reviewed twice a year. The licensee's Direct-Care Staff Plan undated, indicated the director of health services would develop and was accountable to implement a	0 470		

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0 470	Continued From page 3 staffing plan to provide an adequate number of qualified direct care staff to meet the residents' needs 24- hours a day, seven days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report timely to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R4) who had a fall with a serious injury. 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).	0 620		

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0 620	Continued From page 4 The findings include: On January 9, 2023, at 10:51 a.m., during entrance conference, licensed assisted living director (LALD)-A stated Vulnerable Adult (VA) reporting expectations were to make a MAARC report immediately but no greater than 24 hours. R4's diagnoses included heart failure, anxiety disorder, glaucoma, and recurrent falls. R4's Resident Incident Report dated September 9, 2022, indicated R4 was walking in the dining room not using his walker, carrying a cup of coffee, lost his balance and fell. Injuries noted on the report were R4 obtained an abrasion (cut) to the back of the head. R4's Progress Note dated September 9, 2022, indicated R4 had a fall in the dining room and obtained an one inch cut on the back of his head which formed a hematoma (a pooling of blood under the skin). After the fall, R4 complained of left hip pain, and R4 was sent to the emergency department (ED) for an evaluation. R4's Progress Notes dated September 10, 2022, indicated R4 was admitted to the hospital for hip fracture and would be having a surgical consult. A review of the MAARC Common Entry Point Report for the above noted incident indicated the incident had been reported to MAARC on September 13, at 4:56 p.m. (three days after the incident). On January 11, 2023, at 10:12 p.m., LALD-A stated R4's incident should have been reported to MAARC within 24 hours after the licensee	0 620		

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0 620	Continued From page 5 confirmed R4 had fractured his hip as a result from the fall. LALD-A stated she did not file the MAARC report within 24 hours because she though the incident did not meet the required reporting criteria because R4's fall had been witnessed. The licensee's Incident Reporting (Involving Clients, Independent Residents/Visitors, and Staff) policy dated December 2, 2020, indicated the incident must be reported to the Common Entry Point, the director of health services (DHS) or executive director (ED) will make the report as soon as possible and no later than 24 hours after the incident, consistent with the vulnerable adult reporting policy, unless DHS or ED has verified that other staff have already called the Common Entry Point regarding the incident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 650 SS=E	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	0 650		

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0 650	Continued From page 6 qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for two of three employees (unlicensed personnel (ULP)-H, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 650		

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0 650	Continued From page 7 ULP-H ULP-H had a start date of November 4, 2019, and began providing assisted living services on August 1, 2021. ULP-H's employee record included two previous performance evaluations conducted on May 3, 2021, and December 21, 2020. ULP-H's employee record lacked the following: - documentation of annual performance reviews that identify areas of improvement needed and training needs. ULP-I ULP-I was hired on November 15, 2021, to provide assisted living services to the licensee's residents. ULP-I's employee record included the following: -a job description unauthenticated by the licensee and employee. ULP-I's employee record included the following documents which were completed prior to ULP-I's hire date of November 15, 2021: -a performance evaluation conducted on September 11, 2019; and -a background study clearance completed July 1, 2015. On January 11, 2023, at approximately 9:30 a.m., licensed assisted living director (LALD)-A verified the above contents were missing from the employee records. On January 11, 2023, at 12:40 p.m., LALD-A stated ULP-I worked at the licensee's attached transitional care unit (TCU) and was hired at the assisted living facility November 15, 2021.	0 650		

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0 650	Continued From page 8 LALD-A confirmed ULP-I's employee records provided to the evaluator were not completed under the AL license. The licensee's Employee Performance Review Process policy, updated November 2020 indicated employee records would include an annual performance review as a result of a formal performance review process. The licensee's Required Training-Annual/Bi-Annual policy, updated January 2022, indicated all staff that perform direct services would complete at least eight hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.	0 660		

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0 660	Continued From page 9 (b) 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 maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms screenings and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of three employees (unlicensed personnel (ULP)-I). 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: The facility's TB risk assessment dated June 14, 2021, determined the setting to be a low risk level. ULP-I started employment on November 15, 2021. On January 10, 2023, at 8:14 a.m., the evaluator observed ULP-I administer R4's scheduled morning medications.	0 660		

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0 660	Continued From page 10 ULP-I's employee record lacked a current health history and symptom screening and a two-step TST or other evidence of TB screening such as a blood test. ULP-I's employee record contained a Baseline TB Screening Tool for Healthcare Workers (HCWs) indicated ULP-I completed a health history and symptom screening on October 29, 2014, and had a second step TST on November 8, 2014, which was completed greater than 90 days prior to ULP-I's hire date of June 14, 2021. On January 11, 2023, at 12:42 p.m., licensed assisted living director (LALD)-A stated they could not find a current TB two-step or symptoms screening in ULP-I's employee record. The licensee's TB Screening and Prevention policy dated November 30, 2020, indicated at the time of hire or transfer of employment to another Breezier site with a different address and prior to contact with clients, the RN will review TB symptoms and TB history with each new employee. In addition to screening for TB history and symptoms, a two-step skin test (TST) or single interferon gamma release assay (IGRA) for M tuberculosis will be administered unless the person's past medical history indicates that a TB skin test is contraindicated. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first	0 660		

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	30338	A. BUILDING: _____ B. WING _____	01/11/2023

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0 660	Continued From page 11 step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients and a baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. 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	0 800		

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0 800	Continued From page 12 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on January 10, 2023, at approximately 11:30 a.m. with Environmental Services Director (ESD)-J and Maintenance Technician (M)-K, it was observed that garbage cans were partially blocking the marked exit doors in the main floor elevator lobby exit vestibule. Marked exit routes are required to be kept clear of objects that prevent the full and immediate use of the exit. It was also observed that two sprinkler heads had paint on the bulb of the head in the bathroom and closet of resident room 108 B. Sprinkler systems are required to be maintained according NFPA 25 and the manufactures listing of the head. It was observed that a sprinkler head in the closet of resident room 114 A and B had masking tape on it and did not have the ceiling trim installed. Sprinkler systems are required to be installed according to the manufactures listing of the head. Combustible storage was observed in the mechanical room in the required service access and clearance to combustibles space for the heating appliances and electrical equipment. The space is required around these appliances and electrical equipment to reduce the risk of fire hazards and to provide access for service and emergency responders. It was observed the toilet was loose at the connection to the floor in the main lobby men's public restroom.	0 800		

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0 800	Continued From page 13 It was observed the toilet was loose at the connection to the floor in the tub room on the second floor near the elevator. These deficient conditions were visually verified by ESD-J and M-K accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or 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	0 810		

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0 810	Continued From page 14 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). A record review and interview were conducted on January 10, 2023, at approximately 10:15 a.m. of documents provided by Environmental Services Director (ESD)-J and Maintenance Technician (M)-K on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation	0 810		

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0 810	Continued From page 15 indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows: Record review of the available documentation indicated the plan was not maintained specifically for the licensed assisted living facility. The fire safety and evacuation plan provided during the record review and interview was maintained for the adjacent nursing home facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include fire protection procedures for residents in the event of a fire or similar emergency. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for employees in regard to resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Record review of the available documentation and interview indicated that the licensee did not locate the fire safety and evacuation plan in a readily available location in the licensed assisted living facility. The available plan was located in the adjacent nursing home facility. Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter. Record review of the available documentation indicated that the licensee did not provide training to residents who are capable of self-evacuation	0 810		

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0 810	Continued From page 16 on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. All deficiencies were verified by ESD-J and M-K during the interview at approximately 11:15 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to:	01060		

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01060	Continued From page 17 (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative. Further, the licensee failed to notify the Office of Ombudsman for Long-Term Care of resident relocation within four days for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4 was admitted to licensee on March 23, 2022. R4's Progress Notes dated September 10, 2022, indicated R4 was admitted to the hospital post fall	01060		

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01060	Continued From page 18 for right hip fracture. R4's Progress Notes dated September 19, 2022, indicated R4 had a short term stay at a transitional care unit (TCU) from September 13, 2022, to October 19, 2022, post hip fracture and returned to the licensee on September 19, 2022. R4's record lacked documentation R4 or R4's designated representative received an emergency relocation notice with all required content, and further R4's record lacked documentation the Ombudsman was notified of R4's relocation of more than four (4) days. On January 11, 2023, at 10:54 a.m., regional nurse support (RNS)-E confirmed the licensee had not provided a relocation written notice to R4 or R4's representative, nor had the licensee notified the Ombudsman of R4's relocation. RNS-E stated the licensee was not aware the requirement included hospitalizations and thought it only pertained to permanent resident relocations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring	01290		

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01290	Continued From page 19 self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and clearance was received in affiliation with the assisted living with dementia care license for one of three employees (unlicensed personnel (ULP)-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-I ULP-I was hired on November 15, 2021, to provide assisted living services to the licensee's residents. On January 10, 2023, at 8:14 a.m., the evaluator observed ULP-I administer R4's scheduled morning medications.	01290		

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01290	Continued From page 20 ULP-I's employee record contained a background study clearance, affiliated with the licensee's transitional care unit (TCU) dated July 1, 2015. On January 11, 2023, licensed assisted living director (LALD)-A provide the evaluator with ULP-I's updated background study which indicated ULP-I was affiliated with the licensee effective January 11, 2013. LALD-A stated prior to date, ULP-I's background study was affiliated with the licensee's TCU and not the assisted living as required. The licensee's Background Studies policy dated 2016, indicated all current or prospective employees who have or would have direct contact with residents in an Assisted Living setting would have a background check by the Department of Health Services (DHS) upon hire. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) day	01290		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

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01500	Continued From page 21 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01500		

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01500	Continued From page 22 involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of three employees (unlicensed personnel (ULP)-I, ULP-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-I ULP-I had a start date of November 15, 2021. On January 10, 2023, at 8:14 a.m., the evaluator observed ULP-I administer R4's scheduled morning medications. ULP-H ULP-H had a start date of November 4, 2019, under the comprehensive license and on August 1, 2021, continued providing direct care under the assisted living license.	01500		

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01500	Continued From page 23 On January 10, 2023, at 8:50 a.m., the evaluator observed ULP-H administer R2's scheduled morning medications. ULP-I and ULP-H's employee training records lacked evidence ULP-I and ULP-H successfully completed annual training as required, in the following areas: - training of reporting of maltreatment of vulnerable adults; - review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated material and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; - effective approaches to use a problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.	01500		

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MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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01500	Continued From page 24 On January 11, 2023, at 12:42 p.m., licensed assisted living director (LALD)-A stated the completion of annual training used to be based on the employees start date and effective 2023, annual training would be based on the calendar year and all employees would have their annual training completed by January 31, 2023. LALD-A confirmed ULP-I and ULP-H lacked their required annual training. The licensee's Required Training-Annual/Bi-Annual policy dated August 1, 2022, indicated all staff that perform direct services would complete at least eight hours of annual training for each 12 months of employment to include: -reporting of maltreatment of vulnerable adults; -assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated material and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors; -effective approaches for communication with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement them; -principles of person-centered planning and service delivery;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30338	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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01500	Continued From page 25 -how person-centered planning and service delivery applies to direct support services provided by staff; and -emergency and disaster training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a 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	01620		

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	30338	A. BUILDING: _____ B. WING _____	01/11/2023

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01620	Continued From page 26 by: Based on observation, interview, and record review, the licensee failed to conduct a comprehensive reassessment for one of four residents (R1) with a change in condition. 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: R1's diagnoses included chronic kidney disease (stage 3) and fracture of lumbosacral spine and pelvis. R1's Service Plan dated November 11, 2022, indicated services to include bathing/shower assistance, feeding assist, dressing, grooming, transfer assist, meal prep, monthly vital signs and weight, wound care, medication administration, housekeeping, and laundry. R1's last assessment was completed on November 11, 2022. On January 10, 2023, at 7:55 a.m., the evaluator observed unlicensed personnel (ULP)-H assist a hospice nurse with repositioning, a brief change, and wound care observation of the left shin. The evaluator observed 18 one centimeter (cm) circular scabs on R1's left shin (inaccurately noted in progress notes as right shin) in various stages of healing, all were scabbed over, and no	01620		

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01620	Continued From page 27 signs or symptoms of infection were present. R1's progress notes dated December 20, 2022, indicated wound observation by the hospice nurse, "no changes to wounds, remain scabbed". On December 22, 2022, hospice progress notes indicated hospice provided verbal orders for R1 to be an assist of two staff with a Hoyer lift (type of mechanical lift) at all times going forward due to "decline with contractures". A progress note dated December 29, 2022, indicated R1 received a skin tear measuring two (2) cm by one (1) cm on the right lateral side of the foot. Additionally, the progress note indicated this was caused "when placing hoyer up to resident, the wheel nicked the right lateral side of the foot". On January 10, 2023, at approximately 8:15 a.m., the evaluator asked ULP-H how long R1 had the wounds on his left shin. ULP-H stated R1 had the sores "for a while". ULP-H added staff used to transfer R1 with the E-Z stand (an ambulation aid requiring the ability to stand with mechanical assistance), however, R1 would bump his shins on the crossbar when transferring due to increased weakness and R1 also picked at his scabs while sleeping. On January 10, 2023, at approximately 11:00 a.m., the evaluator and registered nurse (RN)-C reviewed hospice progress notes, licensee progress notes, service plan and assessments for R1. RN-C stated licensee's nurses would conduct a bedside update with hospice weekly for hospice residents, however, hospice manages, monitors, and guides all wound care and changes in condition for hospice residents. RN-C stated licensee's nurses had not completed a reassessment for R1 regarding changes in condition or wound care. RN-C stated she was	01620		

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MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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01620	Continued From page 28 unaware licensee's nurses were responsible for the management and on-going monitoring of wounds or changes in condition for hospice residents. The licensee's Change in Resident Condition Reporting by Unlicensed Staff policy updated August 1, 2021, indicated the nurse is expected to evaluate and investigate the reported change in condition based on best practice and professional nursing judgment to provide for maximum resident health and safety. The licensee's Assessment of Resident - Initial and Ongoing policy dated May 23, 2022, indicated the RN would reassess the resident any time the client [resident] returns from a hospital or nursing home stay, has a change in services, and/or a change in condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication	01730		

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MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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01730	Continued From page 29 management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure sure an individual medication management plan was followed for one of one resident (R3) who stored medications in their apartment. This practice resulted in a level two violation (a	01730		

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	30338	A. BUILDING: _____ B. WING _____	01/11/2023

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MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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01730	Continued From page 30	01730		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 January 9, 2023, at 10:51 a.m., during entrance conference, licensed assisted living director (LALD)-A stated the licensee provided medication management services to include secured medication storage.

R3's diagnosis included multiple sclerosis.

R3's Service plan dated November 16, 2022, indicated R3 received medication set-up and medication monitoring services.

R3's Comprehensive Assessment/Licensed Serviced dated August 19, 2022, indicated R3's medications were kept in a locked cupboard in R3's room.

On January 1, 2023, at 9:22 a.m., R3 stated she administered her own medications after the nurse set her medications up in medication planner (an organizer which contains separate compartments for daily medication storage) and her medications were stored in her cupboard in the kitchen. During R3's morning cares, the evaluator observed R3's medication planner on the counter in the kitchen and observed part of the hardware that secured the padlock missing. Unlicensed personnel (ULP)-L verified and was unaware R3's cupboard was missing a lock and stated R3's

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MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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01730	Continued From page 31 stock of medications were not being securely stored. On January 11, 2023, at 12:40 p.m., LALD-A verified R3's medication management plan indicated R3's medications would be securely stored in R3's room in a locked cupboard. The licensee's Development of Individualized Medication Management Plan policy dated December 2, 2020, indicated a description of how medications managed by the licensee would be stored, based on the client's [resident's] needs, risk of diversion, and consistent with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
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, interview, and record review, licensee failed to date time-sensitive medications with an opened-on date for three of three residents (R8, R10, R11). This practice resulted in a level two violation (a	01890		

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01890	Continued From page 32 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 January 9, 2023, at 10:51 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated the licensee provided medication management services to include medication storage. On January 11, 2023, at 8:10 a.m., the evaluator reviewed the medication cart on the second floor of the assisted living with unlicensed personnel (ULP)-I. R9 R9's opened Albuterol Sulfate and Flovent inhalers (used to treat wheezing and shortness of breath) lacked the date the inhalers were opened and when the inhalers would expire. On January 11, 2023, at 8:16 a.m., the evaluator reviewed the medication cart on the third floor of the assisted living with ULP-I. R8 R8's opened bottle of latanoprost ophthalmic 000.5% eye drop (used to treat increased pressure in the eye) lacked the date the eye drop was opened and when the eye drop would expire. R11 R11's two (2) opened Novolog Flex insulin pens lacked the date the insulin pens were opened and	01890		

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01890	Continued From page 33 when the insulin pens would expire. The manufacturer's instructions for the use of Flovent (fluticasone) dated July 2013, indicated once the product was opened, it may be stored for six (6) weeks if 50 microgram (mcg) strength and up to two (2) months if 100 or 250 mcg strength. The manufacturer's instructions for the use of Xalantan (latanoprost) ophthalmic eye drop dated August 2011, indicated once the eye drop was opened, it may be stored at room temperature for six (6) weeks. The manufacturer's instructions for the use Albuterol inhaler dated September 2017, indicated to throw the inhaler in the trash six (6) weeks after opening the foil pouch or when the counter reads zero (0), whichever comes first. The manufacturer's instructions for the use Novolog insulin dated 2022, indicated opened Novolog should be thrown away after 28 days, even if they still have insulin left in them. On January 11, 2023, at 12:40 p.m., CNS-C stated staff were trained to date and initial on the provided medication labels when eye drops, inhalers and insulins were opened. On January 11, 2023, ULP-I verified there were no opened dates on the above noted medications and stated they have been trained to date eye drops, inhalers, and insulins when opened. The licensee's Development of Individualized Medication Management Plan policy dated December 2, 2020, indicated a description of how medications managed by the licensee would be	01890		

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	30338	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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01890	Continued From page 34 stored, based on the client's [resident's] needs, risk of diversion, and consistent with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in one of one secured memory care unit. This had the potential to affect all 15 residents residing in the memory care unit. 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 a widespread scope (when problems	02070	On January 10, 2023, the immediacy of correction order 2070 was removed. The scope and level remain unchanged.	

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	30338	A. BUILDING: _____ B. WING _____	01/11/2023

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02070	Continued From page 35 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an Assisted Living with Dementia Care license with a bed capacity of 75 residents and had a current census of 49 residents. The physical layout of the facility included a secured memory care (MC) unit located on the first floor off the main commons area of the building and non-secured assisted living units on the second and third floors of the building. On January 9, 2023, at 10:51 a.m., during the entrance conference, licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C confirmed the facility's staffing schedule included two unlicensed personnel (ULP) scheduled on the overnight shift (6:00 p.m. to 6:00 a.m.), one ULP for the MC unit and one ULP for the second and third floors of the assisted living. On January 10, 2023, at 5:50 a.m., the surveyor observed two ULP working in the building. ULP-F in the MC unit, and ULP-G working the second and third floors of the assisted living. On January 10, 2023, at 5:56 a.m., ULP-F confirmed there were only two staff scheduled for the overnight shift, one staff on the MC unit, and one staff for the second and third floors of the assisted living. ULP-F stated there were residents on the assisted living floors that required two-person transfer assistance, and staff from the MC unit would assist when called to the assisted	02070		

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02070	Continued From page 36 living to answer call lights or to assist with resident transfers, leaving the MC unit unattended of staff. On January 10, 2023, at 6:02 a.m., ULP-G confirmed she worked the overnight shift 6:00 p.m. to 6:00 a.m., and on the morning of January 10, 2023, an assisted living resident complained of chest pain and was sent to the emergency room. ULP-G stated she had summoned ULP-F from the MC unit to get the "Grab and Go" packet (resident emergency information for emergency medical services) and to wait at the front entrance to meet the emergency response personnel while ULP-G stayed with the resident on third floor who had reported chest pain. ULP-G stated the licensee's regular staffing pattern was to have one ULP in the MC unit and one ULP for the second and third floors of the assisted living. ULP-G stated she often had to summons ULP on the MC unit, leaving the unit unattended of staff, to assist with either a transfer or assistance in answering call lights when ULP-G was busy with another assisted living resident. On January 10, 2023, at 9:25 a.m., CNS-C provided the surveyor with the licensee's staffing plan and confirmed the staffing plan provided had not been fully developed. On January 10, 2023, at 9:58 a.m., the surveyors reviewed the staffing schedule from December 1, 2022, to January 10, 2023, which indicated only two ULP's were scheduled for the overnight shifts. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated March 1, 2022, indicated three unlicensed direct care staff would be scheduled on the night shift.	02070		

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	30338	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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02070	Continued From page 37 On January 10, 2023, at 11:13 a.m., LALD-A and Regional Nurse Support (RNS)-E stated they were unaware three staff were required for the night shift and stated staff should not be leaving the MC unit to assist in other areas of the building. The licensee's Staffing Plan policy revised May 1, 2022, indicated a minimum of two direct-care staff would always be scheduled and available to assist whenever a resident requires the assistance of two. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02070		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical, or nursing standards for five of five residents (R2, R6, R7, R8, R9) with an assistive device (consumer bed rail). 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,	02310	On January 12, 2023, the immediacy of correction order 2310 was removed. The scope and level remain unchanged.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30338	A. BUILDING: _____ B. WING _____	01/11/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 38 or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses included Dementia. R2's Service plan dated January 1, 2021, indicated R2 received services which included medication management, escort, transfers, grooming, dressing, housekeeping, and laundry. R2's Assessment dated November 4, 2022, indicated R2 needed physical assistance of one for ambulation, escorts, and evacuation. R2's assessment indicated R2 had a bed cane with an open center, however, lacked information the device was installed and used according to manufacturer's guidelines. The assessment lacked evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bed rail recall information and lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. R6 R6's diagnoses included macular degeneration. R6's Service plan dated July 29, 2022, indicated R6 received services which included physical assistance of one with bathing/showering, nail care, monitoring visits, monthly vitals, and assistance with bed making.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30338	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(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
02310	Continued From page 39 R6's Assessment dated December 12, 2022, indicated R6 required assistance of a four-wheel walker for ambulation. The assessment also indicated R6 had a bed bar for repositioning and getting in and out of bed, however lacked information the device was installed and used according to manufacturer's guidelines. Additionally, the assessment lacked evidence the licensee referred to the CSPC for bed rail recall information and lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. R7 R7's diagnoses included multiple sclerosis. R7's Service plan dated October 9, 2021, indicated R7 received services which included transfers, grooming, dressing, housekeeping, and laundry. R7's Assessment dated December 13, 2022, indicated R7 was independent with transfers and ambulation. The assessment also indicated R7 had a bed rail attached to R7's bed to assist with stabilization of transfers in and out of bed and to allow R7's maximum participation with bed mobility; however, lacked information the device was installed and used according to manufacturer's guidelines. Additionally, the assessment lacked evidence the licensee referred to the CSPC for bed rail recall information and lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. R8 R8's diagnoses included atrial fibrillation.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30338	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(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
02310	Continued From page 40 R8's Service plan dated October 18, 2022, indicated R8 received services which included medication management, escort, bathing, compression stockings, housekeeping, and laundry. R8's Assessment dated October 18, 2022, indicated R8 was independent with transfers and ambulation. The assessment inaccurately indicated R8 had a hospital bed rail to assist R8 in self-positioning and getting in and out of the bed; however, R8 lacked information the device was installed and used according to manufacturer's guidelines. The assessment lacked evidence the licensee referred to the CSPC for bed rail recall information and lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. On January 10, 2023, at 12:12 p.m., the surveyor observed a bed cane (consumer bed rail) with an open center on the right side of R8's bed and a bed bar (consumer bed rail) located on the left side of the bed. Both devices were secured to the bed tucked underneath the mattress. R9 R9's diagnosis included macular degeneration. R9's Service plan dated July 6, 2022, indicated R9 received services which included housekeeping and laundry. R9's Assessment dated December 2, 2022, indicated R9 was independent with transfers ambulation. The assessment also indicated R9 had a bed rail attached to R9's bed from home, bed rail was bought from the store, secured to the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30338	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(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
02310	Continued From page 41 bed frame with strap and did not meet FDA guidelines. R9's assessment lacked evidence the licensee referred to the CSPC for bed rail recall information and lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. On January 10, 2023, at 11:50 a.m., clinical nurse supervisor (CNS)-C and regional nurse support (RNS)-E stated bedrail assessments had been completed, but had not included a review of the CSPC for assistive devices or included information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. CNS-C stated she had not verified the bed rails were installed or used consistent with manufacturer's instructions and was unaware of any other nurses within the facility completing the documentation requirements for use of consumer bed rails. The licensee's Assessment of the Safety of Side Rails policy, dated December 2, 2020, noted when a resident utilized a side rail on a bed, the licensee would assess the use, educate the resident or representative about the risk and benefits of the side rails, and verify the side rail in use was a safe design and utilized consistent with the manufacturer's directions and met FDA standards. In addition, it noted the facility would determine as safe by meeting all the requirements below: - The side rail was used consistent with manufacturer's directions; - The side rails were installed securely and maintained in good operating condition, be aware of wobbly rails; and - The side rail design was consistent with the FDA's 2006 recommended dimensional	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30338	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

(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
02310	Continued From page 42 measurements to reduce entrapment, to mean side rail zones 1, 2 and 3 must not exceed 4.75". The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30338	A. BUILDING: _____ B. WING _____	01/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWS ON FAIRVIEW AL	25565 FAIRVIEW AVENUE WYOMING, MN 55092

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02310	Continued From page 43 assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/10/23*
Time: 11:30:00
Report: 1025231004

Food and Beverage Establishment Inspection Report

Location:
Meadows On Fairview Al
25565 Fairview Avenue
Wyoming, MN55092
Chisago County, 13

Establishment Info:
ID #: 0038804
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6512746125
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish machine 180 R, 22 PSI
Violation Issued: No

"Sink & Surface" DDBSA: = at Degrees Fahrenheit
Location: OK (1875)
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Serving kitchen
Violation Issued: No

Process/Item: Turkey
Temperature: 45 Degrees Fahrenheit - Location: Server expo, cooling from ambient
Violation Issued: No

Process/Item: HB egg
Temperature: 41 Degrees Fahrenheit - Location: Server expo
Violation Issued: No

Process/Item: Gravy
Temperature: 160 Degrees Fahrenheit - Location: Serving line
Violation Issued: No

Process/Item: Turkey, deli
Temperature: 41 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Type: Full
Date: *01/10/23*
Time: 11:30:00
Report: 1025231004
Meadows On Fairview Al

Food and Beverage Establishment Inspection Report

Process/Item: Cheese, pkg
Temperature: Degrees Fahrenheit - Location: Cooler, back storage
Violation Issued: No

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

Food service conducted non-contract. Discussed employee health and hygiene, FPLS previous orders corrected, serving kitchen flow for food and utensils (returned to kitchen), cleaning for beverage dispensers, disposition of food sent to rooms (disposable products used, bulk containers not used or returned to kitchen), suppliers, employee exclusion, sanitizing, chemical use for sanitizing, disinfecting.

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 1025231004 of 01/10/23.

Certified Food Protection Manager: Shawn M Pierce

Certification Number: FM70575 Expires: 11/09/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Shawn

Signed: _____
Casey Kipping
Public Health Sanitarian II
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231004

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date 01/10/23
No. of Repeat RF/PHI Categories Out	0	Time In 11:30:00
Legal Authority MN Rules Chapter 4626		Time Out

Establishment	Address	City/State	Zip Code	Telephone
Meadows On Fairview Al	25565 Fairview Avenue	Wyoming, MN	55092	6512746125

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038804		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 01/10/23

Inspector (Signature) Cory Kline