Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

March 5, 2025

Licensee
The Geneva Suites
6200 Parkwood Road
Edina, MN 55436

RE: License Number 418938
Health Facility Identification Number (HFID) 33870
Project Number(s) SL33870015

Dear Licensee:

On January 29, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed July 10, 2024. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective March 5, 2025.

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the July 10, 2024, initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on July 10, 2024, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b-F) - $500.00

The details of the violations noted at the time of this follow-up survey completed on January 29, 2025 (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 $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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 may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33870	A. BUILDING: _____ B. WING _____	R 01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	6200 PARKWOOD ROAD EDINA, MN 55436

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL33870015-2 On January 28, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 01, 2024. At the time of the survey, there were five residents; five receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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{0 480}	Continued From page 1	{0 480}		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	{0 480}		

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{0 480}	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey	
{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) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	{0 810}		

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{0 810}	Continued From page 3 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 staff 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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 28, 2025, at 11:00 a.m., the surveyor entered the facility for a follow-up survey.	{0 810}		

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{0 810}	Continued From page 4 On January 28, 2025, at 12:00 p.m., operational manager (OM)-C and director of operations (DOR)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to include specific fire safety and evacuation measures unique to the facility. The FSEP contained the following discrepancies: The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. The facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. The FSEP indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. The FSEP included standard employee actions to be taken but failed to provide specific procedures for employees to evacuate residents based on the facility's specific layout in the event of a fire or	{0 810}		

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{0 810}	Continued From page 5 similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on January 28, 2025, at 12:20 p.m., DOR-A stated that the policy was a basic policy from a third-party provider and had yet to be modified or updated since the initial survey. DOR-A verified that the fire safety and evacuation plan for the facility lacked these provisions. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift as required by statute. Provided documentation indicated that the drills were conducted on 1/16/25 at 9:50 a.m., 12/30/24 at 11:45 a.m., 11/25/24 at 8:35 a.m., and 10/24/24 at 10:45 a.m., with no further drills being documented. During the interview on January 28, 2025, at 12:20 p.m., OM-C stated that the drills were provided for the a.m. shift only and confirmed	{0 810}		

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{0 810}	Continued From page 6 there were no documented drills for the afternoon and night shift. During the same interview, the surveyor explained to DOR-A that the order would be reissued due to continued non-compliance with previous correction orders. DOR-A acknowledged the above findings.	{0 810}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	{01440}	Not reviewed during this survey	

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

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{01470}	Continued From page 8 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01470}	Not reviewed during this survey	
{01530} SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this	{01530}		

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{01530}	Continued From page 9 initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}		
{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	{01620}	Not reviewed during this survey	

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{01620}	Continued From page 10 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:	{01620}	Not reviewed during this survey	

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 4, 2024

Licensee
The Geneva Suites
6200 Parkwood Road
Edina, MN 55436

RE: Conditional License Number 414428
Health Facility Identification Number (HFID) 33870
Project Number(s) SL33870015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on October 1, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **February 2, 2025**.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 10, 2024, found not corrected at the time of the October 1, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0810 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (b)-(f) - $500.00
0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g) - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on October 1, 2024 (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 $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 may be 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.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

CONDITIONAL LICENSE ISSUED:
MDH will issue The Geneva Suites a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if The Geneva Suites is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

a. **Health Facility Construction Permit:** The Geneva Suites, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, The Geneva Suites, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. **General Contractor:** The Geneva Suites must provide the following to Tim Hanna (Tim.Hanna@state.mn.us) via email within 21-days of the date of this notice:

    i. Name
    ii. License Number
    iii. Contact Information

c. **Egress Window Requirements:** The Geneva Suites will replace at least one window in occupied resident sleeping rooms #4, #5, and #6, meeting the minimum size requirements.

i. Must have a minimum openable width of no less than 20 inches
ii. Must have a minimum openable height of no less than 20 inches
iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if The Geneva Suites is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines The Geneva Suites is in substantial compliance on the follow up survey, MDH will remove the conditions from The Geneva Suites's assisted living facility license, and The Geneva Suites will correct any outstanding violations identified during the survey. If The Geneva Suites is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit
https://forms.web.health.state.mn.us/form/HRD-Appeals-Form.

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

If you have any questions, please contact Tim Hanna directly at: 507-208-8982.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33870	A. BUILDING: _____ B. WING _____	R 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	6200 PARKWOOD ROAD EDINA, MN 55436

(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 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: SL33870015-1 On October 1, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on July 10, 2024. At the time of the survey, there were six residents; six receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		

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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 interview and record review, the licensee failed to develop a fire safety and	{0 810}		

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{0 810}	Continued From page 2 evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on October 1, at 1:00 p.m. with the director of operations (DOR)-A on the fire safety and evacuation plan, fire safety and evacuation training, and fire safety and evacuation drills for the facility. During the interview, record review of the fire safety and evacuation plan, fire safety and evacuation training, and fire safety and evacuation drills for the facility were requested, but one was not provided. DOR-A stated he contacted the housing manager, but the housing manager did not provide any record of the updated fire safety and evacuation plan, evacuation training and drills. DOR-A stated that the housing manager probably did not provide any additional trainings and drills and did not update the fire safety and evacuation plan. On October 1, at 1:30 p.m., surveyor explained to	{0 810}		

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{0 810}	Continued From page 3 DOR-A that the order would be reissued due to continued non-compliance with previous correction orders. DOR-A acknowledged the above findings. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to include specific fire safety and evacuation measures unique to the facility. The FSEP contained the following discrepancies: The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. The facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. The FSEP indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. During the facility tour, it was also observed the posted fire safety and evacuation plan did not show the location and number of resident rooms. The FSEP included standard employee actions to be taken but failed to provide specific procedures for employees to evacuate residents based on	{0 810}		

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{0 810}	Continued From page 4 the facility's specific layout in the event of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview on October 1, 2024, at 1:30 p.m., DOR-A stated he contacted the housing manager, but the housing manager did not provide any record of the updated fire safety and evacuation and confirmed the order would be reissued due to continued non-compliance with the previous correction order TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. During the interview on October 1, 2024, at 1:00 p.m., DOR-A stated he contacted the housing manager and asked for the additional fire safety training record, but the housing manager did not provide any record of the training. DOR-A stated that the housing manager probably did not provide any additional fire safety training to staff and acknowledged the above findings.	{0 810}		

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{0 810}	Continued From page 5 DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. The surveyor requested the fire drill record, and no documentation was provided by DOR-A after the request. During the interview on October 1, 2024, at 1:00 p.m., DOR-A stated he contacted the housing manager and asked for the additional drill record, but the housing manager did not provide any record of evacuation drills for the facility. DOR-A stated that the housing manager probably did not provide any additional drills and acknowledged the above findings.	{0 810}		
{0 820} SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	{0 820}		

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{0 820}	Continued From page 6 failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress, and the licensee had lock hardware that required a code to exit the home on the egress side of the front door. This had the potential to affect all residents, staff, and visitors. 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 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: On October 1, 2024, at 12:00 p.m., the surveyor entered the facility for a follow-up survey and toured the facility with the director of operations (DOR)-A. DOR-A stated that the licensee had not yet installed the new windows, and the facility was working with an architect to replace those windows. During the facility tour, surveyor asked DOR-A to open the windows in the resident bedrooms for measurement and observed the following items: It was observed that occupied resident bedroom 6 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 48 inches in height and 10 inches in width, with a total openable area of 480	{0 820}		

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{0 820}	Continued From page 7 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom 5 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 36 inches in height and 17 inches in width, with a total openable area of 612 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. It was observed that occupied resident bedroom 4 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 37 inches in height and 16 inches in width, with a total openable area of 592 square inches. The windows did not meet the minimum requirements for opening width and did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Surveyor explained to DOR-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. DOR-A verbally confirmed the findings. On October 1, 2024, at 12:30 p.m., DOR-A stated	{0 820}		

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{0 820}	Continued From page 8 that the facility hired an architect for the window replacement project and to work on the required submission to the DLI and the MDH. DOR-A provided the surveyor with the email correspondence with the architect. In the original survey conducted on July 9, 2024, the facility proposed a fire watch as a corrective measure to maintain the residents' safety until the window replacement is completed. During the same interview with DOR-A, survey staff requested the fire watch records for the facility. DOR-A provided the fire watch policy and stated that the facility did not conduct fire watches. During the same facility tour, it was also observed that the front exit doors that lead to the outside of the building had a lock that required a code to exit. It was also observed that an electro-mechanical door closer was installed at the door. The front door was marked as an emergency egress exit on the posted evacuation plan, and an exit sign was posted over it. The surveyor verified with DOR-A that the locks were not tied into the building fire alarm system and would not default to an unlocked (fail-safe) position in the event of a fire or other emergency. During the interview on October 1, 2024, at 12:30 p.m., surveyor explained to DOR-A that the door requiring a code to exit constituted an obstruction of egress and a distinct hazard to life. DOR-A stated the facility was working on getting the ALFDC license and confirmed the current deficiency condition. On October 24, 2024, at 10:00 a.m., during the phone interview, surveyor explained to DOR-A	{0 820}		

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{0 820}	Continued From page 9 that the level three correction order would be issued due to continued non-compliance with previous correction orders. DOR-A acknowledged the above finding and stated that the facility has been maintaining a continuous Firewatch since the follow up survey on October 1, 2024.	{0 820}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action required.	{01440}		

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{01470}	Continued From page 10	{01470}		
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	{01470}		

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{01470}	Continued From page 11 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01470}		
{01530} SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not	{01530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33870	A. BUILDING: _____ B. WING _____	R 10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	6200 PARKWOOD ROAD EDINA, MN 55436

(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
{01530}	Continued From page 12 provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action required.	{01530}		
{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	{01620}		

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{01620}	Continued From page 13 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: No further action required.	{01620}		

Electronically Delivered

August 5, 2024

Licensee
The Geneva Suites
6200 Parkwood Road
Edina, MN 55436

RE: Project Number(s) SL33870015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 10, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33870-015 On July 8, 2024, through, July 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; four receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a	0 790		

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0 790	Continued From page 2 minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required monthly maintenance on fire extinguishers. 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 but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 9, 2024, at 10:00 a.m., survey staff toured the facility with the director of operations (DOR)-A. During the facility tour, it was observed the portable fire extinguishers were tagged, showing the required annual service but lacked records to show the required monthly visual inspections were performed or recorded for all portable fire extinguishers throughout buildings. During the facility tour on July 9, 2024, at 10:00 a.m., DOR-A verified required maintenance had	0 790		

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0 790	Continued From page 3 not been completed. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect 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 July 9, 2024, at 10:00 a.m., survey staff toured the facility with the director of operations	0 800		

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0 800	Continued From page 4 (DOR)-A. During the facility tour, survey staff observed the following items: On the back patio, it was observed that the burnt used cigarettes were disposed of all over the floor and on top of the electrical panel, and a plastic plant pot was filled with burnt used cigarettes, creating a possible fire hazard. In the resident room #5 on the main level, it was observed the ceiling-mounted supply grill was covered with black sticky dust. In the bathroom inside the resident room #5 on the main level, it was observed the following items. - It was observed that the shower booth had considerable brown stains. - It was observed that the vanity top and sink had sticky and had considerable brown stains. - It was observed that the toilet and tile floor were sticky and had considerable brown stains. During the facility tour on July 9, 2024, at 10:00 a.m., DOR-A visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of	0 810		

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0 810	Continued From page 5 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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation, and failed to conduct required evacuation drills as required. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 6 violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on July 9, 2024, at 11:00 a.m. with director of operations (DOR)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to include specific fire safety and evacuation measures unique to the facility. The FSEP contained the following discrepancies: The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. The facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and that residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders.	0 810		

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0 810	Continued From page 7 The FSEP indicated the system was wired directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. During the facility tour with the director of operations (DOR)-A on July 9, 2024, at 10:00 a.m., DOR-A visually verified this deficient condition. During the facility tour, it was also observed the posted fire safety and evacuation plan did not show the location and number of resident rooms. The FSEP included standard employee actions to be taken but failed to provide specific procedures for employees to evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include ways to move, evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on July 9, 2024, at 11:30 a.m., DOR-A stated that the policy was a basic policy from a third-party provider and had yet to be edited or updated to fit the facility. DOR-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TRAINING Record review of the available documentation	0 810		

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0 810	Continued From page 8 indicated employees did not receive training twice per year after initial hire. During the interview on July 9, 2024, at 11:30 a.m., DOR-A confirmed the facility provided only one fire safety training in new hire orientation to employees. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. The surveyor requested the fire drill record, and no documentation was provided by DOR-A after the request. During the interview on July 9, 2024, at 11:30 a.m., DOR-A stated that the licensee discussed the fire drill procedure in quarterly staff meetings, but he could not find any recorded documentations. DOR-A verified this deficient finding. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the	0 820		

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0 820	Continued From page 9 facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. The licensee had lock hardware that required a key to exit the home on the egress side of the front door. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. 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 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 9, 2024, at 10:00 a.m., survey staff toured the facility with the director of operations (DOR)-A. During the facility tour, it was observed that the front exit doors that lead to the outside of the building had a lock that required a code to exit. It was also observed that an electro-mechanical door closer was installed at the door. The front door was marked as an emergency egress exit on the posted evacuation plan, and an exit sign was posted over it. Survey	0 820		

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0 820	Continued From page 10 staff verified with DOR-A that the locks were not tied into the building fire alarm system and would not default to an unlocked (fail-safe) position in the event of a fire or other emergency. During the interview on July 9, 2024, at 10:30 a.m., survey staff explained to DOR-A that the door requiring a code to exit constituted an obstruction of egress and a distinct hazard to life. DOR-A stated he understood the deficiency and would get the lock removed when the building maintenance person was available. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and	01440		

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	33870	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GENEVA SUITES	6200 PARKWOOD ROAD EDINA, MN 55436

(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
01440	Continued From page 11 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of a ULP within 30 calendar days of beginning to provide delegated tasks and thereafter as needed based on performance for one of one employee (unlicensed personnel (ULP)-C). 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 July 9, 2024, between 8:30 a.m., and 9:05 a.m., the surveyor observed ULP-C administer medications to the licensee's residents. ULP-C started employment with licensee on January 22, 2024, to provide assisted living services. ULP-C's record lacked evidence a RN conducted direct supervision within 30 calendar days of performing delegated tasks or thereafter as needed based on performance. On July 10, 2024, at 9:30 a.m., director of operations (DOR)-A stated the licensee had not	01440		

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01440	Continued From page 12 implemented a process yet for the RN to complete a 30-day supervision of staff by observation while performing delegated tasks. DOR-A stated all employee records would be missing supervision records. Finally, DOR-A verbalized the licensee was working with a consultant and planned to put the 30-day RN supervision of staff in place. The licensee's 6.17 Supervision of Staff - Delegated Services dated May 2, 2024, included "1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [Licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff	01470		

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01470	Continued From page 13 responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01470		

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01470	Continued From page 14 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 orientation to include all required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On July 8, 2024, at 10:25 a.m., during the entrance conference, director of operations (DOR)-A stated the licensee utilized courses from an online education training program for some of the employee's orientation. On July 9, 2024, between 8:30 a.m., and 9:05 a.m., the surveyor observed ULP-C administer medications and provide personal cares to the licensee's residents. ULP-C was hired on January 22, 2024, and provided direct care services for residents. ULP-C's employee record lacked the following required orientation content: -Overview of Minnesota Assisted Living Statute 144G and Minnesota Rules Chapter 4659; -an introduction and review of the facility's	01470		

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01470	Continued From page 15 policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On July 10, 2024, at 9:30 a.m., DOR-A and clinical nurse supervisor (CNS)-B stated, via phone call, they were not able to find ULP-C's documentation of the required orientation to the assisted living regulations so it may not have been completed. Additionally, DOR-A verbalized he planned to assign ULP-C the required training to be completed. The licensee's 5.01 Orientation of Staff and Supervisors & Content dated May 31, 2024, included, "Orientation must be completed once for each staff person and is not transferable to another provider. 1. All [Licensee] employees must complete the orientation to assisted living facility requirements before providing assisted	01470		

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01470	Continued From page 16 living services to residents. 2. The materials and/or type of training (i.e., video, lecture, reading, etc.) will be documented for compliance. 3. The orientation must contain the following topics: -An overview of the appropriate Assisted Living statutes and rules; -An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -Handling of emergencies and use of emergency services; -Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -A review of the types of assisted living services the employee will be providing and the facility's category of licensure; -The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job	01470		

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01470	Continued From page 17 is to be performed; -The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services; and -The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the	01530		

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01530	Continued From page 18 requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees had completed at least eight (8) hours of initial dementia training within 160 working hours of the employment start date for two of two employees (unlicensed personnel (ULP)-C, licensed practical nurse (LPN)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 9, 2024, between 8:30 a.m., and 9:05 a.m., the surveyor observed ULP-C administer medications and provide personal cares to the licensee's residents. ULP-C ULP-C had a hire date of January 22, 2024, and provided direct care to residents. ULP-C's employee record included six hours of	01530		

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01530	Continued From page 19 dementia training, missing two hours of the required eight hours within 160 hours of employment start date. LPN-D LPN had a hire date of January 24, 2024, and provided direct care to the residents. LPN-D's employee record included two hours of dementia training, missing six hours of the required eight hours within 160 hours of employment start date. On July 9, 2024, at 9:58 a.m., director of operations (DOR)-A and clinical nurse supervisor (CNS)-B stated the licensee communicated with their human resource department to see if there was any additional documentation of dementia training for ULP-C and LPN-D. On July 10, 2024, at 9:30 a.m., DOR-A stated the licensee's human resource department was not able to find additional documented dementia training for ULP-C and LPN-D. DOR-A also verbalized the licensee may have missed assigning the correct amount of hours for dementia training to both ULP-C and LPN-D. Also, DOR-A verbalized ULP-C and LPN-D did not have the full eight hours of dementia care training completed within the required time frame of 160 hours on their training transcripts. The licensee's 3.01 ALDC Additional Dementia Staff Training dated June 4, 2024, included "It is the policy of [Licensee] that staff who work with residents with Alzheimer's disease and other dementia's have proper training for the tasks assigned." No further information provided.	01530		

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01530	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days	01620		

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01620	Continued From page 21 after admission for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On July 8, 2024, at 10:20 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee completed assessments upon admission, at 14 days, every 90 days, and with changes in condition. On July 9, 2024, at 7:25 a.m., surveyor observed ULP-C to assist R2 with personal cares, catheter cares, and medication administration. R2 was admitted October 12, 2023, and had diagnoses including amyotrophic lateral sclerosis (ALS) (a neurodegenerative disorder) and monoclonal gammopathy (abnormal protein in the blood). R2's signed service agreement dated June 12, 2023, indicated R2 received services including assistance with housekeeping, meals, personal cares, bathing, continence cares, treatment, and medication management. R2's medical record included an initial comprehensive nursing assessment, dated October 12, 2023, and a 90-day assessment dated January 12, 2024, 93 days after start of services. R2's record lacked a 14-day	01620		

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01620	Continued From page 22 assessment. On July 9, 2024, at 11:43 a.m., CNS-B stated R2's 14-day assessment was not completed. Also, CNS-B verbalized the nurse opened the nursing assessment for R2 within the electronic medical record, but did not close the nursing assessment timely, and the licensee is unable to have this corrected. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated June 10, 2024, included "3. 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." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Type: Full
Date: *07/09/24*
Time: 12:00:00
Report: 8041241124

Food and Beverage Establishment Inspection Report

Location:
The Geneva Suites
6200 Parkwood Road
Edina, MN55436
Hennepin County, 27

Establishment Info:
ID #: 0039323
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122088888
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.

2-100 Supervision

2-103.11EF ***** Priority 2 *****

MN Rule 4626.0035EF The person in charge must ensure employees verify food delivered and received at the facility is: obtained from approved sources; delivered at required temperatures; protected from contamination, and adulteration. Food received during non-operating hours must meet the standards identified above and must be properly stored, including if necessary refrigerated.

RECEIVING TEMPERATURE LOG INDICATED THERE WERE SOME DAYS HOT TCS FOOD WAS RECEIVED BELOW 135F FROM COMMISSARY KITCHEN. RECEIVING TEMPERATURE REQUIREMENTS FOR HOT AND COLD TCS FOODS REVIEWED DURING INSPECTION. FACT SHEET PROVIDED.

Comply By: 07/09/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: kitchen refrigerator: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: kitchen refrigerator: sour cream
Violation Issued: No

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

Inspection was completed with Leslie Kemp. Dede Hinnendael was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection.

This establishment has a residential kitchen. Food must be prepared for same day service only. Food is prepared by the commissary kitchen in Bloomington and hot/cold meals are delivered daily (3pm). The

kitchen has wood cabinets with a hollow base, solid surface countertop and quarry tile flooring.

Facility has a two basin sink and separate handwashing sink located in the kitchen. Bosch dishwasher has a sanitize cycle and achieved a temp. at least 160F for sanitizing dishes.

Discussed the following:
- Employee illness policy and logging requirements
- Handwashing
- Receiving temperatures, monitoring and transportation of food
- Thermometer use and calibration
- Food storage and preventing cross contamination
- Date marking
- Restrictions concerning serving a highly susceptible population
- Vomit clean up process

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 8041241124 of 07/09/24.

Certified Food Protection Manager: Leslie Kemp

Certification Number: fm112097 Expires: 07/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Leslie Kemp
Culinary Director

Signed: Sarah Conboy
Sarah Conboy
Public Health San. Supervisor
651-201-3984
sarah.conboy@state.mn.us