DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 25, 2025

Licensee
Artis Senior Lvg Of Woodbury
8155 Afton Road
Woodbury, MN 55125

RE: Project Number(s) SL36092016

Dear Licensee:

On July 9, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 12, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

Electronically Delivered

June 16, 2025

Licensee
Artis Senior Lvg Of Woodbury
8155 Afton Road
Woodbury, MN 55125

RE: Project Number(s) SL36092016

Dear Licensee:

On May 1, 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 on February 12, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 12, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 12, 2025, found not corrected at the time of the May 1, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1290 - Background Studies Required - 144g.60 Subdivision 1 - $3,000.00

The details of the violations noted at the time of this follow-up survey completed on May 1, 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 $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

We urge you to review these orders carefully. If you have questions, please contact Renee Anderson at 651-201-5871.

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,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36092	A. BUILDING: _____ B. WING _____	R 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LVG OF WOODBURY	8155 AFTON ROAD WOODBURY, MN 55125

(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 SL#36092016-1 On April 30, 2025, through May 1, 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 February 12, 2025. At the time of the survey, there were 49 residents; 49 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders are 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.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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{0 480}	Continued From page 1 (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}		

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{0 480}	Continued From page 2 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 follow up survey.	
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by:	{0 800}	Not reviewed during this follow up 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	{0 810}		

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{0 810}	Continued From page 3 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 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:	{0 810}		
{01290} SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	{01290}	Not reviewed during this follow up survey.	

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{01290}	Continued From page 4 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to obtain a cleared Department of Health and Human Services (DHS) background study, prior to having access to resident information or contact with residents, for one of seven employees (unlicensed personnel (ULP)-M). In addition, the licensee failed to obtain a cleared DHS background study, affiliated with the licensee's health facility identification number (HFID), prior to contact with residents, for four of seven employees (director of maintenance (DM)-C, ULP-N, director of culinary services (DCS)-O, ULP-P). 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	{01290}		

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{01290}	Continued From page 5 portion or all of the residents). The findings include: BACKGROUND STUDY ULP-M was hired August 3, 2022, and provided direct care services to the licensee's residents. ULP-M's employee record lacked evidence of a cleared DHS background study. AFFILIATION DM-C, ULP-N, DCS-O, and ULP-P were hired October 7, 2019, November 30, 2020, March 2, 2020, and November 30, 2020, respectively, and provided direct services to the licensee's residents. DM-C, ULP-N, DCS-O, and ULP-P's employee records contained documentation of a cleared DHS background study dated December 18, 2019, November 17, 2020, February 12, 2020, and November 17, 2020, respectively, however, the background studies had been submitted through the providers previous license, HFID 35609. DM-C, ULP-N, DCS-O, ULP-P's employee records lacked evidence the licensee ensured a cleared background study was obtained, affiliated with the surveyed assisted living license, HFID 36092. On May 1, 2025, at 8:33 a.m., executive director (ED)-L stated, via phone, he recently started employment with the licensee and believed the background study process was corrected at the time of the last survey completed on February 12, 2025. ED-L verbalized he realized now there needed to be a new process created to ensure background studies and clearance letters are in place for all employees with the licensee's current	{01290}		

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{01290}	Continued From page 6 HFID number. ED-L stated ULP-M currently provided cares to the licensee's residents and he planned to take ULP-M off the work schedule until the licensee received a cleared background study for ULP-M. Finally, ED-L verbalized the licensee has begun the process today to affiliate the other employees to the licensee's current HFID number. The licensee's Background Check policy revised November 15, 2016, indicated, "At the Company, we pride ourselves on providing the highest level of quality care. One of the best ways to give our residents and their family's peace of mind that we have a safe and secure environment is to ensure we hire and maintain a workforce of high integrity. To this end, we conduct criminal background checks on all new hires, rehires, transfers and current associates. Background checks may include verification of any information on the applicant's resume or application form. The applicant for the position must authorize in writing this criminal background investigation. All offers of employment are conditioned on receipt of a background check report that is acceptable to the Company. All background checks are conducted in conformity with the Federal Fair Credit Reporting Act, the Americans with Disabilities Act, and state and federal privacy and antidiscrimination laws. Reports are kept confidential and are only viewed by individuals involved in the hiring process. Although a disqualification is possible, in accordance with federal and state laws, a previous conviction may not automatically disqualify an applicant from consideration for employment with the Company. Depending on a variety of factors, the candidate may still be eligible for employment with the Company. The Company will inquire only about convictions and probation status, if any, and not	{01290}		

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{01290}	Continued From page 7 about arrests unless required by applicable laws." No further information was provided.	{01290}		
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries	{01370}		

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{01370}	Continued From page 8 between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by:	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	{01380}	Not reviewed during this follow up survey.	
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	{01440}	Not reviewed during this follow up survey.	

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{01440}	Continued From page 9 (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 follow up survey.	
{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	{01620}		

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{01620}	Continued From page 10 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:	{01620}	Not reviewed during this follow up survey.	
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all	{01640}		

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{01640}	Continued From page 11 services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by:	{01640}	Not reviewed during this follow up survey.	
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this follow up survey.	
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service	{01910}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36092	A. BUILDING: _____ B. WING _____	R 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01910}	Continued From page 12 contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}		
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by:	{01960}	Not reviewed during this follow up survey.	
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the	{02040}	Not reviewed during this follow up survey.	

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{02040}	Continued From page 13 requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}	Not reviewed during this follow up survey.	

Electronically Delivered

March 12, 2025

Licensee
Artis Senior Lvg Of Woodbury
8155 Afton Road
Woodbury, MN 55125

RE: Project Number(s) SL36092016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 12, 2025, 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 . . ."

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.

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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.

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,

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36092	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LVG OF WOODBURY	8155 AFTON ROAD WOODBURY, MN 55125

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0 000	Initial Comments 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: SL36092016-0 On February 10, 2025, through February 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 57 residents; 57 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was issued February 10, 2025, for SL36092016-0 correction tag 1290. The licensee submitted an acceptable plan of correction; the scope and severity remain at level 3, isolated. An immediate correction order was issued February 11, 2025, for SL36092016-0 correction tag 2310. The licensee submitted an acceptable plan of correction; the scope and severity remain at level	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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0 000	Continued From page 1 3, widespread.	0 000		
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	0 480		

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0 480	Continued From page 2 a two-compartment sink for use only as a handwashing sink; (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: 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 10, 2025, for the specific	0 480		

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0 480	Continued From page 3 Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 800		

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0 800	Continued From page 4 a large portion or all of the residents). The findings include: On February 10, 2025, from 11:00 a.m. to 1:45 p.m., the surveyor toured the facility with director of maintenance (DM)-C. The following was observed: Multiple resident room doors in the 200, 300, and 400 neighborhoods were blocked in the open position with door chocks. The resident room doors were equipped with closers, smoke seal strips on the frames, and tags on both the door and the frame identifying them as fire doors. Of the rooms observed to be propped open the surveyor did not see staff providing care. DM-C stated that the doors sometimes get propped open, and they have advised staff to not prop doors when they are not providing care to residents. Resident room doors are not allowed to be propped open when staff are not providing resident care. 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) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 5 (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 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 the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 810		

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0 810	Continued From page 6 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 February 10, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Alarm Procedures", failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case 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 included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. The section of the FSEP that described full evacuation included instructions to evacuate from the building to the front parking lot and across the street to the "Pep Boys" parking lot. There is no "Pep Boys" parking lot across the street. The FSEP must be maintained with	0 810		

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0 810	Continued From page 7 current and relevant information. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated that staff receive training on the FSEP at orientation and annually thereafter. No other training documentation was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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01290	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain a Minnesota Department of Human Services (DHS) background study clearance prior to providing services for two of four employees (director of life enrichment (DLE)-D, and unlicensed personnel (ULP)-E). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: BACKGROUND STUDY ULP-E was hired on September 28, 2023, and provided direct care and services to the licensee's residents. On February 10, 2025, at 12:50 p.m., the surveyor reviewed the licensee's DHS NETStudy 2.0 roster with the licensed assisted living director (LALD)-A and director of business services (DBS)-F. ULP-E's employee record included a background study clearance form dated September 8, 2023. The licensee's NETStudy 2.0 Roster indicated ULP-E's NETStudy determination was documented as "Eligible-No Longer Valid." As to	01290	The licensee submitted an acceptable plan of correction; the scope and severity remain at level 3, isolated.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01290	Continued From page 9 whether supervision was required, the NETStudy roster indicated, "Remove". ULP-E's employee record lacked evidence of a current cleared background study, affiliated with the licensee's health facility identification (HFID) on the DHS Net Study 2.0 Roster. COVID-19 STUDY- EXPIRED DLE-D was hired on August 30, 2021, and provided direct care and services to the licensee's residents. The licensee's Net Study Roster indicated DLE-D's Net Study determinations were documented as "Eligible-COVID-19 Study-Expired." DLE-D's employee record included a background study clearance form, dated August 24, 2021, while the COVID-19 fingerprinting waiver was in effect. The record lacked evidence of a cleared background study, with fingerprinting, completed since December 31, 2022, when the waivered clearance expired. On February 10, 2025, at 1:20 p.m., LALD-A and DBS-F were not aware of the expired COVID-19 waiver study for DLE-D. LALD-A and DLE-D verbalized they would initiate a background study for DLE-D immediately. LALD-A stated the licensee's corporate team were involved with ULP-E's background study and she would follow up with them with any additional information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		

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01370	Continued From page 10	01370		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 11 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed with all required content for one of two employees (unlicensed personnel (ULP)-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 February 10, 2025, at 10:25 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated initial training, and competency was provided by the licensee's nurse. Also, LALD-A verbalized the licensee's orientation and training was completed in person and they used an internally created corporate training program. ULP-I was hired on December 3, 2022, to provide direct care services to residents of the assisted living facility with dementia care. On February 11, 2025, from 7:56 a.m., until 8:23 a.m., the surveyor observed ULP-I assist residents with personal cares. ULP-I's employee record lacked documentation	01370		

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01370	Continued From page 12 of training and competency evaluations for all ULP including: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; and -awareness of commonly used health technology equipment and assistive devices. On February 11, 2025, at 12:04 p.m., regional vice president (RVP)-G stated the training and competency items missing in ULP-I's employee were not found, so they were not completed. The licensee's 3.04 Training and Competency Evaluations for Unlicensed Personnel policy dated November 1, 2019, indicated, "5. Training and competency evaluations for all ULP's shall include: a) documentation requirements for all services provided b) reports of changes in the resident's condition to the supervisor designated by the home care provider c) basic infection control, including blood-borne pathogens	01370		

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01370	Continued From page 13 d) maintenance of a clean and safe environment e) appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) training on the prevention of falls for providers working with the elderly or individuals at risk of falls g) standby assistance techniques and how to perform them h) medication, exercise, and treatment reminders i) basic nutrition, meal preparation, food safety, and assistance with eating j) preparation of modified diets as ordered by a licensed health professional k) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) understanding appropriate boundaries between staff and residents and the resident's family n) procedures to utilize in handling various emergency situations o) awareness of commonly used health technology equipment and assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn	01380		

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01380	Continued From page 14 (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluation was completed with all required content for one of two employees (unlicensed personnel (ULP)-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 February 10, 2025, at 10:25 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated initial training, and	01380		

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01380	Continued From page 15 competency was provided by the licensee's nurse. Also, LALD-A verbalized the licensee's orientation and training was completed in person and used an internal corporate training program. On February 11, 2025, from 7:56 a.m., until 8:23 a.m., the surveyor observed ULP-I assist residents with personal cares. ULP-I was hired on December 3, 2022, to provide direct care services to residents of the assisted living facility with dementia care. ULP-I's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On February 11, 2025, at 12:04 p.m., regional vice president (RVP)-G stated the training and competency items missing in ULP-I's employee were not found, so they were not completed. The licensee's 3.04 Training and Competency Evaluations for Unlicensed Personnel policy dated November 1, 2019, indicated "5. Training and competency evaluations for all ULPs shall include: p) observation, reporting, and documenting of resident status q) basic knowledge of body functioning and	01380		

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01380	Continued From page 16 changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel r) reading and recording temperature, pulse, and respirations of the resident s) recognizing physical, emotional, cognitive, and developmental needs of the resident t) safe transfer techniques and ambulation u) range of motioning and positioning v) administering medications or treatments as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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	01440		

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01440	Continued From page 17 performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for two of two employees (unlicensed personnel (ULP)-H, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 February 11, 2025, from 7:56 a.m., until 8:23 a.m., the surveyor observed ULP-I assist residents with personal cares. On February 11, 2025, from 9:00 a.m., until 9:31 a.m., the surveyor observed ULP-H assist residents with personal cares. ULP-H and ULP-I were hired on June 7, 2023, and December 3, 2022, respectively, to provide direct care services to residents of the assisted living facility with dementia care. ULP-H and ULP-I's employee records both	01440		

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01440	Continued From page 18 lacked documentation of a 30-day supervision of a delegated nursing task to include observation of the staff administering the medication or treatment and the interaction with the resident. On February 11, 2025, at 12:04 p.m., regional vice president (RVP)-G stated the 30-day supervisions of a delegated task were missing in ULP-H and ULP-I's employee record, so they were not completed. The licensee's undated Operating Standards Human Resources policy, included, "C. Ongoing Training, 1. Ensure all employees maintain a minimum job competency." In addition, included, "4. Maintain 100% compliance with State mandatory in-service requirements." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
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	01620		

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01620	Continued From page 19 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 after start of services for one of three 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 10, 2025, at 10:25 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition.	01620		

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01620	Continued From page 20 R2 was admitted on December 14, 2021, and received services including housekeeping, laundry, meals, dressing, grooming, toileting, bathing, safety checks, and medication administration. On February 11, 2025, at 9:00 a.m., the surveyor observed ULP-H assist R2 with personal cares and mechanical lift transfer. R2's medical record included an initial comprehensive RN assessment, dated December 28, 2021, and a subsequent nursing assessment dated April 19, 2022, greater than 14 days after start of services. On February 11, 2025, at 12:46 p.m., CNS-B stated she found R2's 14-day was completed late. CNS-B verbalized she was recently hired for the licensee and was in the process of ensuring the licensee's nursing tasks were being completed as required. The licensee's Resident Service Plan/Level of Care Assessment policy, updated March 2024, indicated the level of care assessments were to be completed initially prior to move-in, 30 days after move in, 120 days following 30-day, after a hospital stay of one week, after a significant change, and annually. The policy did not indicate a 14-day assessment was required, as per 144G statutes. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01640	Continued From page 21	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure revised service plans were authenticated by the resident or resident's representative for two of three residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01640		

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01640	Continued From page 22 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 February 11, 2025, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-H provide personal cares and mechanical lift transfer for R2. R2 R2 had diagnoses including dementia, hypothyroidism, and depression. R2's Service Plan signed December 14, 2021, indicated R2 received services including assistance with dressing: prompting/cueing, grooming: prompting/cueing, toileting: assistance of 1 as needed, bathing: assistance of 1, weekly housekeeping and laundry, reminders to attend meals and activities, hourly safety checks, reminders to use mobility device during ambulation, and daily medication administration. R2's unsigned Service Plan dated February 11, 2025, printed during the survey, indicated services had changed as follows: -bathing: total assistance, effective January 25, 2024; -bathing: hospice assist, effective August 16, 2024; -dining: dependent, effective January 25, 2024; -dressing: physical assist of two, effective January 25, 2024; -dental care: full assist, effective January 29, 2024; -grooming: assist (resident can participate), effective August 31, 2023; -hospice coordinated care, effective August 31,	01640		

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01640	Continued From page 23 2023; -vital signs, as of March 1, 2022; -medication management: complex, effective March 1, 2022; -ambulation: non-ambulatory physical assist of 2, effective January 25, 2024; -transfer: mechanical lift transfer assist of 2, as of January 9, 2024; -toileting: dependent, effective April 19, 2022; and -skin care with ointment/cream/lotion, effective January 25, 2024. R2's medical record lacked an updated service plan with signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. R4 R4 had diagnoses including Alzheimer's disease (memory loss), and atrial fibrillation (irregular heart rate). R4's Service Plan signed May 17, 2022, indicated R4 received services including assistance with housekeeping, laundry, dining: reminders, dressing: cue/prompt, grooming: cue/prompt, bathing: cue/prompt, brace assist to right wrist, dental care: cues/remind, safety checks, vital signs and medication management: basic. The service plan indicated R4 was independent with toileting and transfers. R4's unsigned Service Plan dated February 12, 2025, printed during the survey, indicated services had changed as follows: -bathing: some assistance, effective August 4, 2022; -behavior management, effective June 1, 2022; -dining: reminders and escort, effective March 2, 2022;	01640		

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01640	Continued From page 24 -mechanical soft diet, effective February 6, 2025; -dressing: assist, effective August 4, 2022; -toileting dependent, effective August 4, 2022; and -no longer receiving assistance with brace to the right wrist. R4's medical record lacked any additional service plans between May 17, 2022, and when printed during the survey by the licensee on February 12, 2025. R4's medical lacked an updated service plan with signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. On February 12, 2025, at 8:10 a.m., clinical nurse supervisor (CNS)-B stated the licensee had not completed revised service plans for R2 and R4 to include authentication or signature from licensee and the residents or their designated representatives. In addition, CNS-B verbalized she was in the process of getting all residents service plans updated and authenticated. The licensee's Resident Service Plan/Level of Care Assessment policy dated March 2024, indicated, "To assure a systematic, comprehensive approach for assessing each prospective resident to determine his/her care tier/care level and obtain information necessary to develop an individualized Resident Service Plan." In addition, included, "4. The Service Plan Assessment items are scored according to their specific need. Their care needs are then used to determine the resident's billable tier. 5. Thirty days following move-in, the resident's level of care is reassessed using the Service Plan Assessment to determine if the resident's care	01640		

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01640	Continued From page 25 level/tier has changed. 6. Thereafter, ongoing level of care assessments are completed at least every 120 days by the DHW or designee (or as per residence policy). 7. The Service Plan Assessment is used as the basis for developing the Resident Service Plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with opened or expiration dates for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01890		

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01890	Continued From page 26 The findings include: R3's medical record included an unsigned Service Plan dated February 12, 2025, during the survey, and indicated R3 received assistance including blood glucose monitoring, and medication administration. On February 11, 2025, at 7:27 a.m., the surveyor observed licensed practical nurse (LPN)-J assist R3 with blood glucose testing, and insulin administration. The licensee's locked medication cart included two opened Basaglar (long-acting insulin) pens for R3. LPN-J administered 33 units of Basaglar insulin to R3 according to R3's provider orders. R3's Basaglar insulin pens lacked an opened date to indicated when it was first opened and used. LPN-J stated the caregivers were trained by the nurse to label the insulin pens when opened but this must have been missed. The manufacturer's instructions for Basaglar insulin pens revised August 26, 2022, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. On February 11, 2025, at 10:43 a.m., clinical nurse supervisor (CNS)-B stated the staff were trained to label and date multi-use insulin pens when opened. CNS-B verbalized she planned to complete additional education with the staff. The licensee's Medication Management policy reviewed January 2023, indicated, "It is the policy of this residence that medication management and administration is performed by staff authorized by [Licensee] standards and State regulations, in accordance with current physician	01890		

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01890	Continued From page 27 orders and acceptable administration practices." The licensee's 5.13 Storage of Medications policy revised November 1, 2019, indicated, "Medications shall be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	01910		

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01910	Continued From page 28 Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R1). 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: R1 had diagnoses including Alzheimer's disease (memory loss), hypertension (high blood pressure), and depression. A discharged resident roster provided by the licensee indicated R1 started receiving services April 2, 2024, and was discharged September 25, 2024. R1's electronic medical record service plan dated September 25, 2024, the date of R1's discharge, indicated R1 received services including assistance with laundry, dressing, grooming, bathing, transfers, safety checks, and medication administration. R1's record included a discharge summary progress note, dated September 25, 2024. The discharge summary indicated, "Resident discharged to episcopal homes via private family transport. She was picked up at 1:45 pm	01910		

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01910	Continued From page 29 [sic]Medications were sent with resident, and family transported. All personal belongings were removed from the suit [sic]. Resident had no skin concerns at time of discharge." R1's record lacked evidence of the disposition of R1's medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On February 11, 2025, at 10:43 a.m., clinical nurse supervisor (CNS)-B stated R1's medication disposition documentation was missing from R1's medical record. The licensee's Medical Records policy updated January 2023, indicated, "6. All medical records of discharged residents shall be completed within 60 days following the discharge date, unless the state regulations require a lesser or greater period of time for completion of the discharged record. All such records will be retained for seven (7) years, or longer if required by state regulations." No further information provided. Time period for correction: Twenty-one (21) days	01910		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must	01960		

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01960	Continued From page 30 include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment administration, or indication why the treatment was not administered as ordered, for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 had diagnoses including encephalopathy (a change in how your brain functions), dementia (memory loss), and type two diabetes. R3's medical record included an unsigned Service Plan dated February 12, 2025, during the survey, and indicated R3 received services including assistance with blood glucose monitoring, and medication administration. On February 11, 2025, at 7:27 a.m., the surveyor observed licensed practical nurse (LPN)-J assist R3 with blood glucose testing and insulin	01960		

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01960	Continued From page 31 administration. R3's medication administration record (MAR) dated January 11, 2025, to February 10, 2025, indicated R3 received blood glucose testing three times daily, less than 30 minutes before meals. R3's medical record included a signed provider order dated July 30, 2024, with directions to check blood sugars twice daily. On February 12, 2025, at 11:25 a.m., clinical nurse supervisor (CNS)-B stated staff had been assisting R3 with blood glucose testing three times daily. CNS-B verbalized it appeared there was a transcription error and R3's blood glucose testing had not been updated yet in the electronic medical record according to R3's provider order. Also, CNS-B stated she talked with R3's provider and verified they wanted twice daily blood glucose monitoring to be implemented as ordered. The licensee's 5.01 Medication & Treatment Orders policy, dated November 1, 2019, indicated "PROCEDURE: 1) The RN is responsible for assuring that current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records, communicated to the resident or responsible party, educate resident or responsible party on all medication and treatment orders, and that changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order.	01960		

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01960	Continued From page 32 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. 5) The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. 6) The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. 7) A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to	02040		

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02040	Continued From page 33 protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property. This deficient practice had the ability 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) 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 the residents). Findings include: A record review of available documentation and interview were conducted February 10, 2025, at 1:45 p.m., with licensed assisted living director (LALD)-A, on the hazard vulnerability assessment (HVA) for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During an interview on February 10, 2025, at 2:15 p.m., LALD-A, stated an HVA had not been performed and documented on and around the property.	02040		

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02040	Continued From page 34 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for two of two residents (R2, R5) who utilized hospital-style bed rails and one of one resident (R4) who utilized consumer-style portable bed rails. 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: HOSPITAL-STYLE BED RAILS R5 R5 had diagnoses which included dementia.	02310	The licensee submitted an acceptable plan of correction; the scope and severity remain at level 3, widespread.	

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02310	Continued From page 35 On February 10, 2025, at 11:42 a.m., the surveyor observed R5's bedroom. R5's bedroom door was open, and R5 was lying on their back in a hospital-style bed. The bed included bilateral upper side rails. Both siderails were in the up position. R5's record included a Side Rail Use Assessment Form dated January 25, 2025. The assessment indicated, under recommendations, "Side Rails are indicated due to the following medical conditions/symptoms: seizure." R5's medical record lacked documentation of measurements of Food and Drug Administration (FDA)-identified zones of entrapment. R2 R2 had diagnoses which included dementia, hypothyroidism, and chronic kidney disease (CKD). On February 11, 2025, at 9:00 a.m., the surveyor observed R2's bedroom with unlicensed personnel (ULP)-H. R2 was lying on her back in bed. The hospital-style bed included bilateral upper side rails. The left side rail was in the up position and the right side rail was in the down position. R2's record included a Side Rail Use Assessment Form dated January 26, 2025. The assessment indicated, under recommendations, "Side Rails are indicated and serve as an enabler to promote independence. Side rails are indicated due to the following medical conditions/symptoms: Resident is on hospice, and siderails are indicated for promotion of mobility, comfort and support."	02310		

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02310	Continued From page 36 R2's medical record lacked documentation of measurements of FDA-identified zones of entrapment. CONSUMER-STYLE PORTABLE BED RAILS R4 had diagnoses which included Alzheimer's disease. On February 11, 2025, at 7:47 a.m., the surveyor observed R4's bedroom. R4's bedroom door was open and R4 was observed lying in his bed. The bed included a "Halo" consumer-style portable side rail on both sides of R4's bed. R4's medical record lacked a side rail assessment to determine appropriate and safe use of the bed rail. The licensee lacked evidence to show the following requirements for R4: -the consumer-style portable bed rails were installed and maintained per manufacturer guidelines; -education was provided to the resident and/or their representative on the benefits and risks of bed rails; and -evidence the licensee ensured the consumer-style portable bed rails were not recalled by the Consumer Product Safety Committee (CPSC). On February 11, 2025, at 1:35 p.m., clinical nurse supervisor (CNS)-B stated the licensee did not have a process to identify when a resident used a hospital-style or consumer-style bed rail when she was first hired to assist the facility. CNS-B also stated she had not completed bed rail assessments with measurements of entrapment zones for R2 and R5 and CNS-B verbalized the licensee's electronic medical record did not have	02310		

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02310	Continued From page 37 the functionality to add in actual measurements. CNS-B stated she did have the manufacturer directions for R4's consumer-style bed rail but had not documented or checked the CPSC website for recalls. On February 11, 2025, at 2:20 p.m., CNS-B stated R4 did not have a side rail assessment completed. Also, CNS-B verbalized she was in the process of getting R4's side rail assessment completed during the survey. The licensee's Mobility Devices policy dated July 2000, indicated, "Supportive devices such as Halo bars, ¼ side rails, enabler bars, etc. (where permissible by state) and state-approved bed mobility bars may be utilized. These devices are meant to assist the resident's ability to turn in bed. If at any time the resident is unable to utilize these devices, mobility device will be discontinued immediately." In addition, included, "4. Side rail/enabler bar MUST meet state guidelines/specifications." The Food and Drug Administration (FDA)'s, A Guide to Bed Safety, dated March 10, 2006, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH)	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36092	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTIS SENIOR LVG OF WOODBURY	8155 AFTON ROAD WOODBURY, MN 55125

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02310	Continued From page 38 website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated December 12, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." In addition, included, ""If a licensee is unable to locate manufacturer's guidelines, they are unable to assess and determine if the portable bed rail is being used appropriately and installed properly." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DEPARTMENT OF HEALTH

Type: Full
Date: *02/10/25*
Time: 17:03:56
Report: 1036251026

Food and Beverage Establishment Inspection Report

Location:

Artis Senior Lvg Of Woodbury
8155 Afton Road
Woodbury, MN55125
Washington County, 82

Establishment Info:

ID #: 0038167
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514932840
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO CHLORINE TEST STRIPS ON SITE FOR MEASURING THE DISH MACHINE SANITIZER CONCENTRATION. MDH PROVIDED A FEW TEST STRIPS UNTIL MORE CAN BE OBTAINED.

Comply By: 03/03/25

Surface and Equipment Sanitizers

Chlorine: = 50PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

QUATERNARY AMMONIA: = 300PPM at Degrees Fahrenheit
Location: 3 COMP SINK SANITIZER DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 36 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -5 Degrees Fahrenheit - Location: WALK IN FREEZER
Violation Issued: No

Type: Full
Date: *02/10/25*
Time: 17:03:56
Report: 1036251026
Artis Senior Lvg Of Woodbury

Food and Beverage Establishment Inspection Report

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS DEDE HINNENDAEL. INSPECTION CONDUCTED IN PRESENCE OF JAHMALA, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE SURVEYOR AND PERSON IN CHARGE DURING INSPECTION.

ADDITIONAL TOPICS DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- NO BHC WITH RTE FOODS.
- THERMOMETER USE AND CALIBRATION.
- DATE MARKING TCS FOODS.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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

I acknowledge receipt of the inspection report number 1036251026 of 02/10/25.

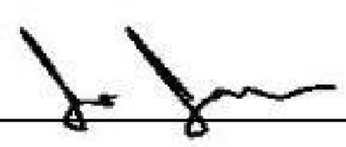
Certified Food Protection Manager KRIS ALMSTED

Certification Number: 39910 Expires: 01/07/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

JAHMALA
PERSON IN CHARGE

Signed: 

Jeff Johanson