Electronically Delivered

August 9, 2023

Licensee
The Pillars Of Prospect Park
22 Malcolm Avenue Southeast
Minneapolis, MN 55414

RE: Project Number(s) SL36252015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0100 - 144g.10 Subdivision 1 - License Required = $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required = $3,000.00
St - 0 - 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 $6,500.00**. 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 the MDH within 15 calendar days of the correction order receipt date.

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

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

Please address your cover letter for reconsideration requests to:

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

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 MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36252	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF PROSPECT PARK	22 MALCOLM AVENUE SE MINNEAPOLIS, MN 55414

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36252015-0 On July 10, 2023, through July 13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 206 residents; 97 of whom received services under the provider's Assisted Living Facility with Dementia Care license. Immediate correction orders were identified on July 10, 2023, issued for SL36252015-0, tag identification 1290 and 2310. On July 12, 2023, the immediacy of correction orders 1290 and 2310 was removed, however, non-compliance remained at a widespread level three violation.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 100 SS=F	144G.10 Subdivision 1 License required	0 100		

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0 100	Continued From page 1 (a)(1)?Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter.? (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).? (b)?The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.? (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).? (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.? (e) Upon approving an application for an assisted living facility license, the commissioner may:? (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or? (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted	0 100		

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0 100	Continued From page 2 living facility with dementia care. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain accurate licensure to include application and approval for an innovation variance as defined in 144G.33 prior to the licensee advertising and offering intergenerational (student) housing. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). 144G.33 INNOVATION VARIANCE. Subdivision 1. Definition; granting variances. (a) For purposes of this section, "innovation variance" means a specified alternative to a requirement of this chapter. (b) An innovation variance may be granted to allow an assisted living facility to offer services of a type or in a manner that is innovative, will not impair the services provided, will not adversely affect the health, safety, or welfare of the residents, and is likely to improve the services provided. The innovative variance cannot change any of the resident's rights under the assisted living bill of rights. Subd. 4.Applications; innovation variance. An application for innovation variance from the requirements of this chapter may be made at any time, must be made in writing to the	0 100		

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0 100	Continued From page 3 commissioner, and must specify the following: (1) the statute or rule from which the innovation variance is requested; (2) the time period for which the innovation variance is requested; (3) the specific alternative action that the licensee proposes; (4) the reasons for the request; and (5) justification that an innovation variance will not impair the services provided, will not adversely affect the health, safety, or welfare of residents, and is likely to improve the services provided. The facility was licensed as an Assisted Living with Dementia Care (ALFDC) and had a license effective, April 1, 2023, for a capacity of 210 residents. Student Resident Documentation acquired during survey included: -Student Residence Program Handbook; -Student Residence Program Agreement; -Student Residence Program Description; -Ebenezer Volunteer Agreement/Handbook Acknowledgement; -Pillars Onboarding Student Housing & Level 1 Partnership; -Student Housing - Intake Form; and -Rental History Report for R8 for Pillars of Prospect Park (Ebenezer). The Student Residence Program Description indicated, "The Pillars of Prospect Park Student Residence Program allows students to enjoy a beautiful, unfurnished studio apartment in our newly constructed senior living community and to engage with the older adults living at The Pillars of Prospect Park in an intergenerational housing program. Students will make a commitment to interact, as student volunteers, with The Pillars of	0 100		

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0 100	Continued From page 4 Prospect Park older adult residents for no less than 10 hours per month through student-led and student-planned pre-approved activities. Students will also have the opportunity to lead an art class, music program or fitness program, and can also engage with our older adult residents at mealtime or social hours. This program will help older adults and students build relationships through telling stories, learning from the past and sharing the future." During the entrance conference on July 10, 2023, licensed assisted living director (LALD)-C stated the licensee had 11 student residents, and it was the licensee's second year for student housing where they leased studio apartments at a student reduced rate. LALD-C stated the student residents were not localized to one area of the facility and were intermixed with independent living (residents not receiving services) and assisted living (residents receiving services) resident population. The student residents were required to volunteer 10 hours of their time per month to the residents in the facility. 144G.08 DEFINITIONS. Subd. 59.Resident. "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. Refer to 144G.50 for Assisted Living Contract requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100		

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0 480	Continued From page 5	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 10, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 6 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of five employees (unlicensed personnel (ULP)-K) observed to provide personal cares. 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 July 11, 2023, at 10:04 a.m., surveyor observed as ULP-K hand sanitized, donned (applied) gloves, and entered R11 and R12's apartment (roommates). ULP-K obtained vital signs (temperature, blood pressure, pulse, respirations, and oxygen saturation level). The	0 510		

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0 510	Continued From page 7 oxygen saturation level required application of a measuring device on R11's finger. ULP-K recorded the results of the vital signs on the phone (electronic health record program) with gloved hands. ULP-K then placed a scale on the floor next to R11 to obtain his weight. After obtaining R11's weight, ULP-K placed the scale onto the kitchen table where R11 was sitting reading the newspaper. ULP-K brought the vital sign equipment into the bedroom of the apartment and asked R12, who was lying in bed, to obtain her vital signs. ULP-K doffed (removed) gloves, hand sanitized, and donned new gloves before obtaining R12's vital signs. ULP-K recorded the results onto the phone with gloves on. R12 indicated to ULP-K she had vomited 5 times that morning and was feeling "woozy." Upon completion of assigned tasks in R11 and R12's room, ULP-K gathered all equipment, exited the room, and placed the equipment into the medication cart. Surveyor did not observe any cleaning of the phone or equipment. On July 11, 2023, at approximately 10:15 a.m., surveyor asked ULP-K when the phone should be cleaned. ULP-K stated it should be cleaned after entering each apartment and that the cart should be disinfected. Surveyor then asked when the vital sign equipment should be cleaned and ULP-K stated, "I should have done it, you are making me nervous." During an interview on July 12, 2023, at 2:13 p.m., director of nursing (DON)-A expected equipment to be cleaned in between each resident and that phones should be cleaned if dirty gloves were touching it. The licensee's Standard Infection Control Precautions policy dated March 25, 2016, last	0 510		

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0 510	Continued From page 8 reviewed on August 1, 2022, indicated staff to remove gloves promptly after use, and before touching non-contaminated items, environmental surfaces, self, or other clients (residents). The policy also indicated reusable equipment is appropriately cleaned and reprocessed prior to use on another client and that single-use items are properly discarded. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure tuberculosis (TB) testing was completed at the time of hire, or	0 660		

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0 660	Continued From page 9 within 90-days prior to the date of hire, for 11 student resident volunteers. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The Facility TB Risk Assessment dated February 10, 2023, identified the facility was at a low risk for TB transmission. The licensee had 11 student residents who attended local colleges. The student residents rented an apartment from the licensee and were required to work as volunteers with residents for the facility 10 hours each month. As a volunteer required to work with residents regularly: Per statute 144G.08 Subdivision. 56., the volunteers met the criteria as being a regularly scheduled. "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine." R8, a student resident, moved into the licensee on August 14, 2022. R8 was considered an independent living (IL) (housing only) resident and did not receive services under the assisted living facility with dementia care (ALFDC) license. R8's records included a Student Residence Program Agreement (lease) signed on July 27, 2022, which indicated a date of possession of August 10, 2022.	0 660		

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0 660	Continued From page 10 R8's record lacked TB screening and testing. R8 was a regularly scheduled volunteer for the licensee to meet the licensee's Student Residence Program requirement. The Student Resident Program Description dated April 2022, indicated, "Students will make a commitment to interact, as student volunteers, with The Pillars of Prospect Park older adult residents for no less than 10 hours per month through student-led and student-planned pre-approved activities. Students will also have the opportunity to lead an art class, music program or fitness program, and can also engage with our older adult residents at mealtime or social hours. This program will help older adults and students build relationships through telling stories, learning from the past and sharing the future." Volunteers who share airspace with patients (residents) must meet the following requirements: -TB history and symptom screening; and -TB screening testing to be completed with a IGRA or TB Gold blood test or a two-step Mantoux. On June 10, 2023, at 10:05 a.m., licensed assisted living director (LALD)-C stated they had a student resident program in which 11 college students currently lived in the facility intermixed with independent living (residents not receiving services) and assisted living (residents receiving services) resident population. On June 10, 2023, at 1:50 p.m., LALD-C stated the student/resident/volunteers were not screened for TB as the licensee did not believe they were subject to the same screening requirements as staff members due to their	0 660		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF PROSPECT PARK	22 MALCOLM AVENUE SE MINNEAPOLIS, MN 55414

(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
0 660	Continued From page 11 status as residents. The MDH guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated , "Volunteers who share airspace with patients for five to 10 hours or more per week should receive the same TB screening as paid HCWs (health care workers)." Further, the guidelines noted training was required at the time of hire and included: pathogenesis, signs symptoms, and the licensee's infection control plan. In addition, baseline screening for all HCW included a history and symptom screen and testing for the presence of TB infection. The guidelines noted a blood test should include the date of the test and if a HCW had documentation for latent TB, that documentation could be substituted for documentation of a previous positive TST or blood test. The licensee's TB Screening and Prevention policy dated November 30, 2020, indicated: "3. TB screening for Staff and Volunteers A. At the time of hire or transfer of employment to another Ebenezer site with a different address and prior to contact with clients, the RN will review TB symptoms and TB history with each new employee. Volunteers who share airspace with clients for 10 hours or more per week must follow the TB screening required for staff. B. In addition to screening for TB history and symptoms, a two-step skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis will be administered unless the person's past medical history indicates that a TB skin test is contraindicated. An employee may begin working with clients after a negative TB symptom screen and a documented negative	0 660		

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0 660	Continued From page 12 IGRA or first step TST dated within 90 days before hire. The second TST may be performed after the employee starts working with clients. An employee who has a documented negative TST result in with the past 12 months required only a single TST. This single TST must be administered prior to client contact and is considered the second stage of the two-step process." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 730 SS=E	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans;	0 730		

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0 730	Continued From page 13 (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document services were provided as identified in the service plan for three of five residents (R5, R6, R9). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be	0 730		

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0 730	Continued From page 14 pervasive). The findings include: R5 On July 10, 2023, at 11:29 a.m., the surveyor observed unlicensed personnel (ULP)-B provide medication administration to R5. R5's Service Plan Agreement dated February 24, 2023, indicated R5 received assistance with bathing, safety checks, dining reminders, dressing, grooming, oral care, vital signs, homemaking, laundry, and medication administration. R5's July 2023, Service Checkoff List lacked documentation for the following services: -vital signs, four missed documentations; -dining reminders, two missed documentations; -medication administration, ten missed documentations; and -safety checks, 13 missed documentations. R6 On July 12, 2023, at approximately 8:00 a.m., the surveyor observed ULP-I and ULP-M provide dressing, transfers, and toileting to R6. R6's Service Plan Agreement dated February 1, 2023, indicated R6 received assistance with bathing, dining reminders, toileting reminders, grooming reminders, dressing, medication administration, homemaking, and laundry. R6's July 2023, Service Checkoff List lacked documentation for the following services: -toileting, 23 missed documentations; -care alert-anticoagulant, 11 missed documentations;	0 730		

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0 730	Continued From page 15 -vital signs, one missed documentation; -dressing, five missed documentations; -ambulation cueing, one missed documentation; -grooming, one missed documentation; -homemaking, one missed documentation; -medication administration, 15 missed documentations; -laundry, three missed documentations; -dining reminders, two missed documentations; R9 On July 11, 2023, at 9:09 a.m., the surveyor observed unlicensed personnel (ULP)-J provide shower, dressing, transfers and wheelchair mobility to R9. R9's Service Plan Agreement dated May 25, 2023, indicated R9 received assistance with laundry, dressing, bathing, incontinence care, mobility and transfer assistance, and AFO (ankle/foot orthosis) application for both morning and night. R9's July 2023, Service Checkoff List lacked documentation for the following services: -ambulation, 12 missed documentations; -bed mobility, 12 missed documentations; -housekeeping, one missed documentation; -miscellaneous 05 minute visit-apply barrier cream, 12 missed documentations; -transfer assist, 12 missed documentations; -vitals, one missed documentation; -dressing, 11 missed documentations; -nail care, one missed documentation; -bathing, two missed documentations; -linen laundry, one missed documentation; -toileting, 23 missed documentations; and -safety checks, 11 missed documentations. During interview on July 12, 2023, at 9:35 a.m.,	0 730		

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0 730	Continued From page 16 R10 (significant other of R9) confirmed they returned to the facility Sunday July 2, 2023, and R9 had been receiving scheduled services between July 3, through July 8, 2023. During interview on July 12, 2023, at 12:05 p.m., ULP-K stated if a resident refused a care or it was not done, staff put a note into the resident's chart. If the service documentation was left blank, it meant it was missed charting. ULP-K verified she worked on July 4-7, 2023, and provided the services to R9 but the care plan did not show up on her electronic device. ULP-K stated she contacted the nurse on July 4, 2023, for further instruction and she was told R9 must not have been removed from "leave of absence." During exit interview on July 12, 2023, at 2:13 p.m., DON-A stated the care plan would alert the RN of missed charting, then a nurse would follow up on it, and blank spots on the service documentation meant missed charting. DON-A stated they did not know why the service didn't show up on the care plan once R9 returned from leave of absence on July 2, 2023. The licensee's Client Record policy dated March 1, 2014, last revised on August 1, 2021, indicated the resident record would include documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 17 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide required employee training on fire safety and evacuation. This had	0 810		

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0 810	Continued From page 18 the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on July 12, 2023, at approximately 1:15 p.m. with the Licensed Assisted Living Director (LALD)-C and the maintenance director (MD)-H on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, MD-H and LALD-C stated the employees were offered training at an "All Staff" meeting twice a year, but not all staff attended, and not all staff received their required training. All staff are required to receive training on the fire safety and evacuation plans upon hire and twice per year thereafter. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01290	Continued From page 19	01290		
01290 SS=I	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 an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the licensee for 11 of 11 student residents who were also volunteers for the licensee on a regular scheduled basis. This resulted in an immediate order for correction on July 10, 2023, at approximately 5:30 p.m. 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).	01290	On July 12, 2023, the immediacy of correction order 1290 was removed, however, non-compliance remained at a widespread level three violation.	

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01290	Continued From page 20 The findings include: The licensee had 11 student residents who attended the local colleges. The student residents rented an apartment from the licensee and were required to work as volunteers for the facility 10 hours each month. R8 was a student resident admitted to the licensee on August 14, 2022. R8 was considered an independent living (IL) (housing only) resident and did not receive services under the assisted living facility with dementia care (ALFDC) license. R8's records included a Student Residence Program Agreement (lease) signed on July 27, 2022, which indicated a date of possession of August 10, 2022. R8's record included a background study run through Rental History Reports (www.rentalhistoryreports.com) completed on July 1, 2022. R8 was a regularly scheduled volunteer for the licensee to meet the licensee's Student Residence Program requirement. The Student Resident Program Description dated April 2022, indicated: "Students will make a commitment to interact, as student volunteers, with The Pillars of Prospect Park older adult residents for no less than 10 hours per month through student-led and student-planned pre-approved activities. Students will also have the opportunity to lead an art class, music program or fitness program, and can also engage with our older adult residents at mealtime or social hours. This program will help older adults and students build relationships through telling stories, learning from the past and sharing	01290		

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01290	Continued From page 21 the future." On July 10, 2023, at 10:05 a.m., during the entrance conference licensed assisted living director (LALD)-C stated they had 11 student residents living in the facility who volunteered for 10 hours per month for the licensee as a part of their Student Resident Agreement. On July 10, 2023, at 1:50 p.m., LALD-C provided R8's background study and stated the background checked was run through Rental History Reports and not through the Department of Human Services (DHS) NetStudy2.0 program or affiliated with their HFID (facility identification number). LALD-C stated all 11 of their student residents had background studies run through Rental History Reports. On July 10, 2023, at 3:40 p.m., LALD-C inquired as to why the background study run through Rental History Reports was insufficient, surveyor explained background studies were required for employees and regularly scheduled volunteers of the facility and were subject to the statute background study requirements under the licensee's HFID number. The licensee's Employee Records/File policy revised in May 2022, indicated: "2. Employee file contents: A. The following documents are maintained electronically and can be requested by contacting HRRep@fairview.org: -Job Application -Licensure (if applicable) -Employment Offer Letter -Job Description -Corrective Action -Background checks (VCI and DHS) - contact	01290		

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01290	Continued From page 22 DEPT-CORP-HR-DHS@Fairview.org -LOA Records" No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470		

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01470	Continued From page 23 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure student residents completed required orientation before providing volunteer services for 11 of 11 student residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	01470		

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01470	Continued From page 24 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had 11 student residents who attended local colleges. Each student resident rented an apartment from the licensee and was required to work as a volunteer with residents for the facility 10 hours each month. Per statute 144G.08 Subdivision. 56., the volunteers met the criteria as being a regularly scheduled volunteer. "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine. R8 was a student resident and moved to the licensee on August 14, 2022. R8 was considered an independent living (IL) (housing only) resident and did not receive services under the assisted living facility with dementia care (ALFDC) license. R8's records included a Student Residence Program Agreement (lease) signed on July 27, 2022, which indicated a date of possession of August 10, 2022. R8's record lacked the following required orientation: -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01470		

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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
01470	Continued From page 25 Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. -orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: -an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; -health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or -information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01470		

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01470	Continued From page 26 access in real time, and closed captions During the entrance conference on July 10, 2023, at 10:05 a.m., licensed assisted living director (LALD)-C stated they had 11 student residents living in the facility who were required to work as volunteers with their residents for 10 hours each month. On July 10, 2023, at 1:50 p.m., LALD-C stated the student residents went through an onboarding process with some training, but it was different than their regular employee new hire training. It did not include the orientation items listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01550 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees that did not provide direct care, received at least four hours of initial training on dementia care within 160 working hours of the employment start date for 11	01550		

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01550	Continued From page 27 of 11 student residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had 11 student residents who attended local colleges. Each student resident rented an apartment from the licensee and was required to work as a volunteer with residents for the facility 10 hours each month. Per statute 144G.08 Subdivision. 56., the volunteers met the criteria as being a regularly scheduled volunteer. "Regularly scheduled" means ordered or planned to be completed at predetermined times or according to a predetermined routine. R8 was a student resident and moved to the licensee on August 14, 2022. R8 was considered an independent living (IL) (housing only) resident and did not receive services under the assisted living facility with dementia care (ALFDC) license. R8's records included a Student Residence Program Agreement (lease) signed on July 27, 2022, which indicated a date of possession of August 10, 2022. R8's record lacked required orientation to assisted living facilities licensing requirements	01550		

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01550	Continued From page 28 and regulations. During the entrance conference on July 10, 2023, at 10:05 a.m., licensed assisted living director (LALD)-C stated they had 11 student residents living in the facility who were required to work as volunteers with their residents for 10 hours each month. On July 10, 2023, at 1:50 p.m., licensed assisted living director (LALD)-C stated the student residents went through an onboarding process with some training but it was not the same as their normal employee hiring training. It did not include the required dementia care training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

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01620	Continued From page 29 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) conduct ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for three of five residents (R6, R5, R15). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R6 R6 was admitted to the facility on September 15, 2022, with a diagnosis of cerebral infarction. R6's Service Plan Agreement signed February 1, 2023, and indicated R6 received services for safety checks, bathing assistance, homemaking, laundry, and medication administration.	01620		

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01620	Continued From page 30 R6's record included a Basic Assessment/ULP Services and a Comprehensive Assessment/Licensed Services RN assessment dated February 17, 2023. The next Basic Assessment/ULP Services and Comprehensive Assessment/Licensed Services RN assessment was not completed until July 11, 2023, during the survey and was 54 days past the 90-day requirement. R15 R15 was admitted to the facility on November 3, 2021, with diagnoses of rheumatoid arthritis (chronic inflammation of joints), paroxysmal atrial fibrillation (irregular heartbeat), prediabetes, and major depressive disorder. R15's Service Plan Agreement signed April 17, 2022, indicated R15 received assistance with medication set up, medication reminders, and safety checks. R15's record included a Basic Assessment/ULP Services and Comprehensive Assessment/Licensed Services RN assessment completed on February 26, 2023. On July 11, 2023, at 11:29 a.m., surveyor observed unlicensed personnel (ULP)-K set up R15's medications at the medication cart in the elevator lobby. Upon entering R15's apartment, surveyor and ULP-K observed R15 on the ground of her patio. R15 indicated she had fallen. R15's record lacked any further assessments, therefore, lacked an ongoing resident reassessment and monitoring based on changes in the needs of the resident, not to exceed 90 calendar days from the last date of the	01620		

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01620	Continued From page 31 assessment. The next RN assessment was due by May 27, 2023. R5 R5 was admitted to the facility on October 25, 2022, with a diagnosis of limitations of activities due to disabilities. R5's Service Plan Agreement signed February 24, 2023, indicated R5 received services for safety checks, laundry, and medication administration. R5's record included a Basic Assessment/ULP Services and a Comprehensive Assessment/Licensed Services RN assessment dated November 1, 2022. The next Basic Assessment/ULP Services and Comprehensive Assessment/Licensed Services RN assessment was not completed until February 23, 2023, 24 days past the 90-day requirement but the record did include a RN assessment on June 8, 2023. During the entrance conference on July 10, 2023, at approximately 10:00 a.m., director of nursing (DON)-A stated ongoing RN resident assessments were to be completed every 90 days. On July 12, 2023, at 2:13 p.m., DON-A stated 90-day assessments were not done on time and must have been overlooked. DON-A stated R6's was completed on July 11, 2023, during survey. The licensee's Assessment of Clients-Initial and Ongoing policy dated March 1, 2014, last reviewed on May 23, 2022, indicated an ongoing resident reassessment and monitoring would be conducted as needed, based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 32 calendar days from the resident's last date of the uniform assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure currently written or electronically recorded incomplete prescriptions were clarified for two of five residents (R2, R15). 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: R2 R2's Comprehensive Assessment/Licensed Services dated May 25, 2023, assessed R2	01820		

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01820	Continued From page 33 needed routine medication management. R2's service plan printed July 12, 2023, indicated R2 was receiving the following services: housekeeping, laundry, medication administration, assistance with bathing, dressing, grooming, and safety checks. R2's Medication Sheet dated July 2023, indicated R2 took Lubricating eye drops 0.4-0.3%-instill 1-2 drops in eye(s) once daily. R2's provider orders signed February 8, 2023, ordered Systane 0.4-0.3% eye drop solution-1-2 drops once. The order did not indicate route or frequency. R15 R15's Comprehensive Assessment/Licensed Services document dated February 26, 2023, assessed that R15 needed medication management. R15's Service Plan Agreement signed April 17, 2022, indicated R15 was independent with most things such as showers, dressing/grooming, mobility, toileting, eating and activities. R15 needed assistance with vital signs, housekeeping, laundry, medication set up, and medication reminders. During observation and interview on July 11, 2023, at 11:29 a.m., the surveyor observed unlicensed personnel (ULP)-K set up R15's oral medications then pull out a bottle of eye drops. R15's Medication Sheet also known as the medication administration record (MAR) indicated "polyvinyl AL Sol 1.4% OP-instill drop(s) into eye(s) four time a day, but in another location on the MAR, it indicated to administer one drop.	01820		

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01820	Continued From page 34 Surveyor asked ULP-K how she knew to administer the eye drops and ULP-K stated, "I have been putting it into the right eye because she had cataract surgery in that eye." On July 11, 2023, at 11:50 a.m., ULP-K administered one drop of polyvinyl 1.4% solution to R15's right eye. R15's provider orders dated June 22, 2023, received from M Health Fairview Eye Clinic, indicated "Drops right eye.," then ordered R15 to take artificial tears 4 times a day. R15's provider order lacked instruction on how many drops to administer in the right eye. On July 11, 2023, at 12:25 p.m., registered nurse (RN)-L located the orders from ophthalmology to review R15's polyvinyl eye drops and indicated it did not specify how many drops and said, "that's ophthalmology for you." RN-L indicated she would get the order clarified. On July 12, 2023, at 2:13 p.m., director of nursing (DON)-A indicated the orders should have been clarified by the provider and that ULP's cannot decide how many drops to administer. The licensee's Medication Management Services Documentation policy dated March 1, 2014, last reviewed on August 1, 2021, indicated the client specific MAR/EMAR would include the medication name, dose, route, time and date for administration, and any special instructions including when and how to contact the nurse. The licensee's Medication Prescriptions, Refills, Supplies-Request & Delivery policy dated March 1, 2014, last revised on August 1, 2021, indicated	01820		

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01820	Continued From page 35 the nurse would make any changes to the MAR/EMAR (electronic medication administration record) immediately after receiving a prescription. The policy also indicated the RN would communicate the change to staff responsible for administering the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to lock a medication storage cart while not in use or monitored by staff. This had the potential to affect all residents, staff, and visitors on third floor secured memory care unit. 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:	01880		

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01880	Continued From page 36 During observation and interview on July 10, 2023, at 11:20 a.m., the surveyor observed an unlocked medication cart in the dining room of a secured memory care unit with residents ambulating in the vicinity. The push button locking mechanism was popped out with a key inside the keyhole. The medication cart remained unlocked until unlicensed personnel (ULP)-D returned from the kitchen area (out of view from medication cart) after approximately one minute. It was unknown how long the medication cart was unlocked prior to surveyor's observation. Surveyor asked when it was expected to lock the medication cart and ULP-D stated it must be locked before walking away. On July 10, 2023, at 11:22 a.m., DON-A stated the procedure was to have the medication locked when not in use. The licensee's Storage of Medication and Key Security policy dated September 27, 2021, last revised on April 19, 2023, indicated medication keys are kept in a secure location when not in the possession of authorized personnel. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	01940		

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01940	Continued From page 37 that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R9). 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	01940		

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01940	Continued From page 38 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: During the entrance conference on July 10, 2023, at approximately 10:45 a.m., director of nursing (DON)-A stated the licensee provided and/or could provide treatment management services to residents, including ankle foot orthosis (AFO). R9's record lacked a treatment management plan to include the following required content: - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse when a problem arose with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R9's Service Plan Agreement dated May 25, 2023, indicated R9 received assistance with laundry, dressing, bathing, incontinence care, mobility, and transfer assistance, and AFO application for both morning and night. The service plan did not indicate to remove the AFO at night. R9's prescriber orders dated April 28, 2023, indicated AFO to right lower extremity on in morning and off at night. On July 11, 2023, at 9:39 a.m., unlicensed	01940		

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01940	Continued From page 39 personnel (ULP)-J offered to apply AFO to R9's right foot but R9 declined. During interview on July 12, 2023, at 9:35 a.m., with R9 and R10 (couple living in same apartment), surveyor observed a white hard plastic AFO applied to R9's right lower extremity. On July 12, 2023, during exit conference at 2:13 p.m., DON-A agreed the care plan did not specify to remove the AFO at night. DON-A stated staff would check resident's skin while doing showers once a week but acknowledged there were no specific procedures on when to notify the nurse if a problem arose with the AFO. The licensee's Development of Individualized Treatment Management Plan dated March 1, 2017, last revised on August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - dentification of the type of services that will be provided; - identification of any specific resident instructions regarding treatments or therapy administration; - identification of the person responsible for monitoring any treatment supplies are ordered on a timely basis; -identification of the staff who are responsible for the treatment management tasks, including tasks delegated to unlicensed staff; - procedures for staff to notify a nurse when there was a problem with any treatment management service; - any resident-specific requirements relating to documentation of treatment and therapy completion, verification that all treatment and therapy was administered as prescribed, and	01940		

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	36252	A. BUILDING: _____ B. WING _____	07/13/2023

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01940	Continued From page 40 monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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: Based on observation, interview, and record review, the licensee failed to ensure treatment or therapies were administered as directed and failed to document the reason they were not administered, and any follow up procedures provided to meet the resident's needs for one of five residents (R9) with treatment and/or therapies. 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	01960		

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01960	Continued From page 41 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on July 10, 2023, at 10:05 a.m., director of nursing (DON)-A stated the licensee provided and/or could provide treatment management services to residents, including ankle foot orthosis (AFO) and TED hose (compression stockings). R9's Service Plan Agreement dated May 25, 2023, indicated R9 received assistance with laundry, dressing, bathing, incontinence care, mobility, and transfer assistance, and AFO application for both morning and night. The service plan did not indicate to remove the AFO at night. R9's prescriber orders dated April 28, 2023, indicated AFO to right lower extremity on in morning and off at night. On July 11, 2023, at 9:39 a.m., ULP-J offered to apply AFO to R9's right foot but R9 declined. R9's service record lacked documentation for the following treatments between July 1, 2023, through July 12, 2023: -AFO application to right foot; July 3, 2023, through July 8, 2023, at 7:00 a.m.; -AFO {application} removal from right foot; July 3, 2023, through July 7, 2023, at 8:00 p.m. During interview on July 12, 2023, at 9:35 a.m., surveyor observed a white hard plastic AFO applied to R9's right lower extremity. R10 (significant other of R9) confirmed they returned	01960		

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01960	Continued From page 42 to the facility Sunday July 2, 2023 and R9 had been receiving scheduled services between July 3, through July 8, 2023. During interview on July 12, 2023, at 12:05 p.m., ULP-K stated if a resident refused a care or it was not done, staff put a note into the resident's chart. If the service documentation was left blank, it meant it was missed charting. ULP-K verified she worked on July 4-7, 2023, and provided the services to R9 but the care plan did not show up on her electronic device. ULP-K stated she contacted the nurse on July 4, 2023, for further instruction and she was told R9 must not have been removed from "leave of absence." During exit interview on July 12, 2023, at 2:13 p.m., DON-A stated the care plan would alert the RN of missed charting, then a nurse would follow up on it, and blank spots on the service documentation meant missed charting. DON-A could not indicate why the service didn't show up on the care plan once R9 returned from leave of absence on July 2, 2023. The licensee's Development of Individualized Treatment Management Plan dated March 1, 2017, last revised on August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: - dentification of the type of services that will be provided; - identification of any specific resident instructions regarding treatments or therapy administration; - identification of the person responsible for monitoring any treatment supplies are ordered on a timely basis; -identification of the staff who are responsible for	01960		

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01960	Continued From page 43 the treatment management tasks, including tasks delegated to unlicensed staff; - procedures for staff to notify a nurse when there was a problem with any treatment management service; - any resident-specific requirements relating to documentation of treatment and therapy completion, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR 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 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 with mitigation factors on	02040		

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02040	Continued From page 44 and around the property for the facility. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on July 12, 2023, at approximately 1:15 p.m. with the Maintenance Director (MD)-H on the hazard vulnerability assessment 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 interview, MD-H verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02290 SS=D	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or	02290		

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02290	Continued From page 45 require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of one resident (R2) when the licensee removed the resident's grab bar upon discovery without being assessed by a registered nurse (RN) and without discussing the risk versus benefit or alternatives of using the grab bar with the resident and/or the resident's designated representative. 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 July 10, 2023, at 10:43 a.m., during facility tour, the surveyor observed a black grab bar the shape of an upside-down question mark attached to a wood board which was inserted between the mattress and the bed frame on the right side of the bed. When pulled on the grab bar, it slid out from under the mattress. During interview and observation July 10, 2023, at 11:22 a.m., director of nursing (DON)-A and surveyor walked into R2's room where DON-A observed the grab bar. DON-A stated, "I didn't know it was there. It must be new, and staff didn't	02290		

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02290	Continued From page 46 inform me." DON-A also stated, "I really discourage grab bars in memory care if a resident's memory is not intact." DON-A pulled out the grab bar entirely and surveyor noted a strap connected to the wood board. DON-A placed the grab bar into the resident's closet and walked out. R2 was not present during this time. R2's diagnoses included Parkinson's disease, mild cognitive impairment, osteoarthrosis (cartilage breakdown at the joints), urinary incontinence, and osteopenia (bone loss). On July 10, 2023, at 2:45 p.m., R2 and her spouse (FM) were in R2's room during interview. FM stated the doctor recommended R2 use a grab bar and it had been used by R2 since November of 2022. FM stated he felt the grab bar helped R2, but it took may different positions on the bed to find the best location. The licensee's Exhibit E Minnesota Bill of Rights for Assisted Living Residents document dated July 26, 2022, indicated under 3. Participation in care and service planning: residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes: -the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers; -the right to include the resident's legal and designated representatives and persons of the resident's choosing; and -the right to be told in advance of, and take an active part in decisions regarding, any recommended changes in the service plan. The licensee's Assessment and Use of Side Rails policy last revised on February 1, 2023, indicated	02290		

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02290	Continued From page 47 the nurse would evaluate whether the side rail appears to be appropriate for the [resident] to meet the goal of maximum mobility and independence. The nurse would educate the [resident], the [resident's] representative and/or family members about the risks related to side rails and if the [resident's] side rail did not meet standards, the nurse would remove the siderail and would recommend alternative options. The nurse would document these conversations and recommendations. The policy indicated for "Homestyle beds," the only approved device would be a halo device (round shape). The policy further indicated, if the device is deemed to be inappropriate and the resident refuses to remove the device the facility may decide to terminate the resident agreement due to inability to provide a safe environment that will meet the resident's needs. Per Minnesota State Statute 144G. 91, Subd. 5 Refusal of care or services. Residents have the right to refuse care or assisted living services and to be informed by the facility of the medical, health-related, or psychological consequences of refusing care or services, and Subd. 16 Right to furnish and decorate. Residents have the right to furnish and decorate the resident's unit within the terms of the assisted living contract. Through email correspondence dated July 12, 2023, at 9:31 a.m., licensed assisted living director (LALD)-C indicated, "the only approved FDA device is the Halo, but technically they can use an alternative. The only alternative would be a hospital bed with hospital bed rails." No further information was provided.	02290		

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02290	Continued From page 48 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290		
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, medical or nursing standards for two of three residents (R2, R3) who utilized consumer 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: On July 10, 2023, the licensee provided surveyor with document titled, Current Resident Roster, dated July 10, 2023, a Minnesota Department of Health template. Only one resident (R1) was identified to have a bed rail or consumer bed rail on the facility roster.	02310	On July 12, 2023, the immediacy of correction order 2310 was removed, however, non-compliance remained at a widespread level three violation.	

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02310	Continued From page 49 R2 R2 was admitted to licensee on February 8, 2023. R2's most recent registered nurse (RN) assessment dated May 25, 2023, indicated R2 received services for medication administration, bed mobility, transfer assist of two staff, toileting assistance, dressing and grooming, and safety checks. R2's record lacked identification or assessment of any bed mobility device. R2's resident record included a Bed Rails-Intended Purpose, Potential Risks And Client Agreement dated February 8, 2023, and indicated a bed rail was declined by R2. On July 10, 2023, at 10:43 a.m., surveyor observed a black single grab bar style consumer bed rail in the shape of a question mark on R2's right side of a full or queen sized bed. Surveyor was able to pull the grab bar out from under the bed without resistance. On July 10, 2023, at 2:45 p.m., R2 stated she used the grab bar to help get in and out of bed. R2 also stated she had the grab bar since November 2022. R3 R3 was admitted to licensee on August 30, 2021. R3's resident record included a Bed Rails-Intended Purpose, Potential Risks And Client Agreement dated August 30, 2021, and indicated a bedrail was declined by R3. There was a handwritten note after the declination stating "Mom needs some kind of fall bed protection per doctor's order. We understand we need to use only a Halo safety rail and thus are changing our railings."	02310		

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02310	Continued From page 50 R3's RN assessment dated February 2, 2023, indicated R3 used a Halo grab bar for bed mobility. R3's most recent RN assessment dated May 18, 2023, indicated R3 received services for medication management, bed mobility, transfer assist, toileting assistance, dressing and grooming, and safety checks. R3's assessment lacked identification or assessment of any bed mobility device. On July 10, 2023, at 11:30 a.m., DON-A and surveyor observed two "Halo" grab bars in the shape of a circle fixed to R3's bed frame and stabilized with a platform on the floor. On July 10, 2023, at 12:45 p.m., unlicensed personnel (ULP)-G stated if she saw a bed rail or grab bar appear on any resident's bed, she would notify the RN. On July 10, 2023, at 12:51 p.m., ULP-B stated if she found something that didn't belong in the room, she would contact the RN right away. During interview on July 10, 2023, at 11:20 a.m., director of nursing (DON)-A observed the grab bar on R2's bed and stated she did not know it was there and that it must be new. She then stated staff did not inform her that it was present on R2's bed. DON-A removed the grab bar that was placed between the mattress and bed frame and placed it into R2's closet. The grab bar did have a strap, but it was not attached to the bed frame. When surveyor informed her that R2 stated she had the grab bar since November 2022, DON-A stated, "I don't believe that to be true." When asked who checks to make sure the	02310		

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02310	Continued From page 51 devices are installed correctly, DON-A indicated maintenance was responsible for checking the bed rail/grab bar monthly to ensure they are installed correctly. DON-A also indicated she expected the bed rails to be assessed by the RN every 90 days or when there is a change in condition. During interview on July 10, 2023, at 1:52 p.m., maintenance (M)-H stated he checks the bed rails and grab bars monthly, and he would notify an RN if the measurements were beyond four inches or if a device had been recalled. M-H indicated a supply company (Direct Supply) they use will inform him of any recalls on the devices supplied to licensee. The licensee's Logbook Documentation, last completed on June 26, 2023, by M-H indicated R3's bed device was inspected and had "no gaps." During interview on July 10, 2023, at 3:05 p.m., RN-E stated when an assessment is completed, she interviews with the resident and will compare the information obtained against the RN assessment that forwards the information from the previous assessment. RN-E stated she will make changes based on her in-person assessment. On July 10, 2023, at 3:33 p.m., DON-A indicated RN-E was an agency nurse and may not have recognized the Halo or consumer grab bar as a bed rail and that was why it wasn't assessed on R3's RN assessment dated May 18, 2023. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When	02310		

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02310	Continued From page 52 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) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36252	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF PROSPECT PARK	22 MALCOLM AVENUE SE MINNEAPOLIS, MN 55414

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 53 areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". The FAQ also identified a bed rail assessment must be conducted upon initial installation, with each 90-day assessment, with change of condition, or if the rail is observed to not maintain a consistent secure attachment to the bed frame. The licensee's Assessment and Use of Side Rails policy, last reviewed on December 2, 2020, indicated: -Upon Admission, the nurse will provide education for any client/client representative regarding side rail safety and risks including potential death due to falls, entrapment, and asphyxiation -The nurse will train staff to be alert for any side rail, or equipment that resembles a side rail, that a client may be using or considering using and to notify the nurse immediately about the side rail or equipment. -When notified that a client has a side rail, the nurse will assess and evaluate what the client's needs are and assess to determine if the client can appropriately utilize the side rail/equipment. The nurse will ensure that the device does not inhibit resident from being able to move about freely and is not determined to be a restraint -The nurse will determine whether the side rail/equipment meets the following facility required standards: -Homestyle beds: The only approved device will be a halo device. The device will need to be installed/maintained per manufacturers guidelines. The device will need to be maintained and ensure there are no broken/malfunctioning parts of the rail to remain in place in the resident's	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36252	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 54 apartment. -Hospital Beds: Manufacturer information must be available to the facility and the device must be installed and maintained per manufacturer guidelines. The device must also meet the FDA measurement requirements. -The FDA recommends that the dimensions in Zones 1-4 be less than: -Zone 1: Within the Rail (4.75") -Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support (4.75") -Zone 3: Between the Rail and the Mattress (4.75") -Zone 4: Under the Rail, at the Ends of the Rail (2 and 3/8" and greater than 60° angle) -If the nurse determines that the side rail(s) are not an appropriate device for the client, the device will be removed. The resident/representative will be provided with options and alternatives for addressing resident needs. "Recommendations may include an alternative side rail/transfer bar that meets FDA standards, alternative products, or changes to the service plan. "The nurse will document these recommended options and the response from the client, client's family, and client's representative to the nurse's recommendations. -Devices that are deemed to be appropriate will be assessed on an ongoing basis to ensure appropriateness of device along with input from the maintenance team to ensure the device is in good repair and free of defects, concerns for recall or safety concerns. -If the device is deemed to be inappropriate and the resident refuses to remove the device the facility may decide to terminate the resident agreement due to inability to provide a safe environment that will meet the resident's needs.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36252	A. BUILDING: _____ B. WING _____	07/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PILLARS OF PROSPECT PARK	22 MALCOLM AVENUE SE MINNEAPOLIS, MN 55414

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 55 No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

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

Type: Full
Date: *07/10/23*
Time: 13:00:00
Report: 1013231173

Food and Beverage Establishment Inspection Report

Location:
The Pillars Of Prospect Park
22 Malcolm Avenue Se
Minneapolis, MN55414
Hennepin County, 27

Establishment Info:
ID #: 0037608
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128743477
ID #:

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

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12B

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

A CONTAINER WITHOUT A HANDLE WAS STORED DIRECTLY IN THE FLOUR LOCATED IN THE MAIN KITCHEN BULK FLOUR CONTAINER. DISCUSSED UTENSIL STORAGE WITH STAFF. THE CONTAINER WAS REMOVED.

Corrected on Site

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizer - service area
Violation Issued: No

Quaternary Ammonia: = 300 ppm at Degrees Fahrenheit
Location: Sanitizer - prep area
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Kitchen dish machine
Violation Issued: No

Hot Water: = at 169 Degrees Fahrenheit
Location: Memory care dish machine 1
Violation Issued: No

Hot Water: = at 168 Degrees Fahrenheit
Location: Memory care dish machine 2
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Sliced melon
Temperature: 41 Degrees Fahrenheit - Location: Tall cooler
Violation Issued: No

Process/Item: Salad
Temperature: 41 Degrees Fahrenheit - Location: Tall cooler
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Service area cooler
Violation Issued: No

Process/Item: Ice cream
Temperature: 23 Degrees Fahrenheit - Location: Service area freezer
Violation Issued: No

Process/Item: Hamburger
Temperature: 40 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Process/Item: Chicken
Temperature: 39 Degrees Fahrenheit - Location: Prep cooler
Violation Issued: No

Process/Item: Sliced tomatoes
Temperature: 38 Degrees Fahrenheit - Location: Cold top cooler
Violation Issued: No

Process/Item: Tomato soup
Temperature: 178 Degrees Fahrenheit - Location: Steam table
Violation Issued: No

Process/Item: Grilled cheese
Temperature: 155 Degrees Fahrenheit - Location: Steam table
Violation Issued: No

Process/Item: Chicken
Temperature: 40 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Soup
Temperature: 40 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Yogurt
Temperature: 41 Degrees Fahrenheit - Location: Tall cooler - memory care 1
Violation Issued: No

Type: Full
Date: *07/10/23*
Time: 13:00:00
Report: 1013231173
The Pillars Of Prospect Park

Food and Beverage Establishment Inspection Report

Process/Item: Sliced melon
Temperature: 40 Degrees Fahrenheit - Location: Tall cooler - memory care 2
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluators J. Keen and A. Bohnen.

The operator stated their MN CFPM renewal application was recently submitted.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, sanitizer, food storage, cooling, and food handling procedures.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013231173 of 07/10/23.

Certified Food Protection Manager: Jeremy Switzer

Certification Number: 84075 Expires: 10/18/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jeremy Switzer
Operator

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us