Electronically Delivered

May 8, 2025

Licensee
Royal Age Assisted Living LLC
7047 Goodview Avenue South
Cottage Grove, MN 55016

RE: Project Number(s) SL36630016

Dear Licensee:

On April 15, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on February 20, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Electronically Delivered

March 21, 2025

Licensee
Royal Age Assisted Living LLC
7047 Goodview Avenue South
Cottage Grove, MN 55016

RE: Project Number(s) SL36630016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. 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 MDH within 15 calendar days of the correction order receipt date.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

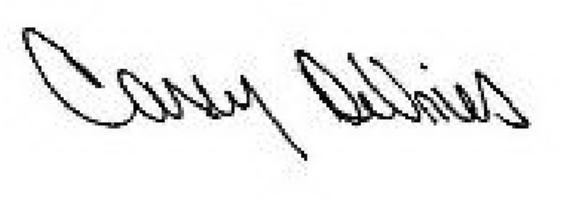
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36630	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL AGE ASSISTED LIVING LLC	7047 GOODVIEW AVENUE SOUTH COTTAGE GROVE, MN 55016

(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 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: SL36630016-0 On February 18, 2025, through February 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license. An immediate order for correction was identified on February 20, 2025, issued for SL36630016-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 18, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice;	0 500		

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0 500	Continued From page 4 (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to provide the following policies and procedures during or after the survey process: - requirements in section 626.557, reporting of maltreatment of vulnerable adults; and - conducting and handling background studies on employees. On February 18, 2025, at 11:47 a.m., clinical nurse supervisor (CNS)-B stated their policy and procedure binder was complete in its content and contained all required policies and procedures related to assisted living services provided by the licensee and they were not aware of any missing	0 500		

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0 500	Continued From page 5 policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 500		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	0 630		

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0 630	Continued From page 6 situation has occurred only occasionally). The findings include: R3 was admitted on September 8, 2023, to receive assisted living services. R3's diagnosis included hyperacusis (a condition resulting in a reduced tolerance to sound), ataxia (a condition resulting in the loss of muscle control in the arms and legs which may lead to lack of balance), developmental disabilities, depression, anxiety, PPD, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder and aphasia (a disorder which affects the ability to speak). R3's unsigned Service Plan (Waiver) - Addendum to contract dated February 19, 2025, indicated R3 received assistance with activities, assistance with appointment reminders, dressing, grooming, housekeeping, incontinence care, escort and mobility assistance, laundry, linen changes, behavior management, medication administration, and care of respiratory equipment. R3's record contained a 90-day assessment dated January 24, 2025 which included a section regarding resident vulnerability. This section indicated R3 was at risk to being abused. This assessment lacked information indicating R3's risk of abusing other vulnerable adults. On February 19, 2025, at 2:13 p.m., clinical nurse supervisor (CNS)-B stated they were unaware R3's record lacked required contents, but going forward, they would ensure all required contents were included in resident IAPP's. The licensee lacked a policy and procedure on	0 630		

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0 630	Continued From page 7 the development of the individual abuse prevention plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training	0 650		

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0 650	Continued From page 8 documentation was maintained for one of three staff (unlicensed personnel ((ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired April 12, 2021, and began providing assisted living services on August 1, 2021. The licensee's Daily Schedule dated for the week of February 16, 2025, indicated ULP-E was scheduled to work February 21, and February 22, 2025, from 11:00 p.m., to 7:00 a.m. On February 19, 2025, at 12:52 p.m., clinical nurse supervisor (CNS)-B stated they were unable to locate ULP-E's employee record, and they were not sure where the record would be. On February 19, 2025, at 2:15 p.m., CNS-B stated that going forward they would improve their record maintenance by filing away records. CNS-B stated they would develop a list of all active employees. CNS-B stated their focus will be that all active employee records are stored together. The licensee's undated Training Records document indicated the assisted living provider must maintain a record of staff training and competency that documents the following	0 650		

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0 650	Continued From page 9 information for each competency evaluation, training, retraining and orientation topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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 interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for two of two employees (clinical nurse supervisor (CNS)-B, and unlicensed personnel	0 660		

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0 660	Continued From page 10 (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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's current TB risk assessment completed May 10, 2024, indicated a low risk level. CNS-B CNS-B was hired on September 15, 2015, and began providing assisted living services, clinical oversight, and supervision of unlicensed personnel on August 1, 2021. CNS-B's employee record contained document titled Preliminary Chest X-Ray Report dated September 12, 2013, with a result that indicated a preliminary finding of "negative". However, the form did not indicate the purpose of the X-Ray. Additionally, there was no prior documentation of a positive TB test to require a chest X-Ray or ongoing symptom screening. ULP-C ULP-C was hired November 21, 2024, to provide assisted living services. ULP-C's record lacked documentation of TB symptom screening or test.	0 660		

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	36630	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL AGE ASSISTED LIVING LLC	7047 GOODVIEW AVENUE SOUTH COTTAGE GROVE, MN 55016

(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 On February 19, 2025, at 1:15 p.., CNS-B stated they thought that when someone gets the BCG vaccine, they did not have to retest once they got an X-Ray. CNS-B stated they did not realize there needed to be documentation of a positive TB test to correlate with a chest X-Ray. CNS-B stated that ULP-C would only have an X-Ray on file but did not know that the X-Ray was not in the employee file and did not know where the documentation would be. On February 19, 2025, at 2:18 p.m., CNS-B stated the plan going forward will be to implement QuantiFERON testing for all TB testing. The licensee's undated Infection Control document indicated "The Infection Control procedures are designed to meet compliance with the OSHA standards for Occupational Exposure to Bloodborne Pathogens and the Minnesota OSHA Tuberculosis directive. They are also designed to meet the Tuberculosis Prevention and Control Guidelines for Home Care Providers." The Minnesota department of health's, "Regulations for Tuberculosis Control in Minnesota Health Care Setting, A guide for implementing tuberculosis (TB) infection control regulations in your facility" dated July 2013 indicated the following: Before the health care worker (HCW) has direct patient contact, the following should be documented in their record: 1. Test result, 2. Assessment for current TB symptoms, 3. Chest X-ray to rule out infectious TB disease. The chest X-ray should be done after the date of the positive TST or IGRA; however, a chest X-ray done within the three months prior to the	0 660		

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0 660	Continued From page 12 TST/IGRA is acceptable, provided that the HCW has not been exposed to infectious TB disease since the chest X-ray was done, and 4. Medical evaluation to rule out a diagnosis of infectious TB disease. The CDC's Morbidity and Mortality Weekly Report, "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, 2005", dated December 30, 2005, indicated the following: HCWs with a baseline positive or newly positive test result for M. tuberculosis infection (i.e., TST or BAMT) or documentation of treatment for LTBI or TB disease should receive one chest radiograph result to exclude TB disease (or an interpretable copy within a reasonable time frame, such as 6 months). Repeat radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a clinician. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 13 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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's undated emergency disaster preparedness plan lacked evidence of the following required content:	0 680		

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0 680	Continued From page 14 - annual review of the EPP; - a written risk assessment utilizing an all-hazards approach; - categorization of probable risks by likelihood of occurrence; - written strategies addressing facility and community-based risks; - missing resident plan; - policies and procedures for tracking of staff and residents; - policies and procedures addressing the development of arrangements with other facilities/providers to receive residents in the event of limitation/cessations of operation to maintain to continuity of services to residents; - roles under wavier declared by secretary; - policies and procedures for providing care and/or treatments at alternative care sites under 1135 waiver; - development and annual review of a communication plan; - names and contact information of staff, entities providing services under agreement, residents physicians, other facilities and volunteers; - emergency officials contact information; and - policies and procedures including primary and alternate means of communicating with facility staff, federal, state, tribal, regional, and local emergency management agencies. On February 18, 2025, at 11:40 a.m., clinical nurse supervisor (CNS)-B stated the provided emergency preparedness plan was complete in its content. On February 19, 2025, at 2:19 p.m., CNS-B stated that they and licensed assisted living director (LALD)-A were responsible for the development of the licensee's EPP. CNS-B stated they were unaware their EPP had missing	0 680		

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0 680	Continued From page 15 required information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private for three of three 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 19, 2025, from 7:27a.m., to 7:56 a.m., the surveyor observed clinical nurse	0 700		

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0 700	Continued From page 16 supervisor (CNS)-B administer medications to residents. At 7:27 a.m., the surveyor observed CNS-B open the licensee's electronic medication administration record (EMAR) on a laptop placed on the top of a medication cart adjacent to the licensee's kitchen, and then leave the computer unattended to wash hands in the kitchen sink on the other side of the kitchen. After preparing medications, the surveyor observed CNS-B leave the EMAR open and unattended from 7:30 a.m., to 7:35 a.m., to administer medications to R2, from 7:46 a.m., to 7:51 a.m., to administer medications to R3, and again from 7:53 a.m., to 7:55a.m., to administer medications to R4. On February 19, 2025, at 8:37 a.m., CNS-B stated they should have secured the computer in between all medication passes. CNS-B stated they were very nervous due to the survey process. The licensee's undated Health records policies and procedures document indicated all information contained in the individual's record will be considered privileged and confidential. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 775 SS=D	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced	0 775		

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0 775	Continued From page 17 by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: During facility tour on February 18, 2025, from 1:00 p.m. to 3:00 p.m., with licensed assisted living director (LALD)-A, emergency escape and rescue opening in unoccupied resident room three only opened 7 inches because there was screw in the track to prevent the window from opening any further. During the interview on February 18, 2025, at 2:00 p.m., LALD-A stated that he put the screw in the track based on the previous tenant's healthcare plan to prevent them from escape or hurting themselves. Windows are not to be restricted from opening, this required special knowledge and use of the window. LALD-A verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		

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0 780	Continued From page 18	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 780		

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0 780	Continued From page 19 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: During facility tour on February 12, 2025, from 1:00 p.m. to 3:00 p.m., with licensed assisted living director (LALD)-A, it was observed that smoke alarm was missing from resident room five and hard-wired alarm was missing in the basement next to the furnace. Smoke alarm in resident room six and outside of same resident room was not interconnected when LALD-A tested. Smoke alarms are required to be in each sleeping room, on each story including the basement and interconnected with each other. During a facility tour on February 18, 2025, at 2:00 p.m., LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and	0 790		

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0 790	Continued From page 20 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required in Minnesota State Fire Code throughout the facility. This deficient condition had the ability to affect all staff, visitors, and 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on February 18, 2025, from 1:00 p.m. to 3:00 p.m., with licensed assisted living director (LALD)-A., The portable fire extinguisher located at the top of second level stairs was mounted over 60" from the floor. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. On February 18, 2025, at 2:00 p.m., LALD-A verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days	0 790		

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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During facility tour on February 18, 2025, from 1:00 p.m. to 3:00 p.m., with licensed assisted living director (LALD)-A, basement was in various states of repair in what was a remodel. Open room at the bottom of the stairs was full of	0 800		

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0 800	Continued From page 22 construction material. The entire basement had several electrical outlets that were not secured or had missing cover plates. There was a room with a shower unit, no toilet or sink, an area with a stove, a sink and cabinets was being completed along with two additional bedrooms down a hallway that no interconnected smoke alarms, no doors, and unfinished floors. On February 18, 2025, at 2:30 a.m., LALD-A, verified the above listed observations while accompanying on the tour. LALD-A stated he was hoping to finish a remodel project in basement, but he could no longer financially support the work. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810		

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0 810	Continued From page 23 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on February 18, 2025, from 1:00 p.m. to 3:00 p.m., with licensed assisted living director (LALD)-A, surveyor observed all	0 810		

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0 810	Continued From page 24 resident rooms lacked identification in accordance with posted evacuation plans. Resident rooms much match posted facility evacuation diagrams for staff, residents and visitors to reduce confusion and potential obstructions during egress of a fire or similar emergency. A copy of the facility floor plan should also be in the emergency preparedness binder to aid first responders in search and rescue operations. On February 18, 2025, LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety training and evacuation drills, for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Policy", dated on 08/1/2021, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.	0 810		

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0 810	Continued From page 25 TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, and reviews emergency preparedness documentation. LALD-A stated they were using evacuation drills as training. No other training documentation was provided. The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On February 18, 2025, at 2:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, titled "Fire Drills", indicated evacuation drills were conducted only during the AM shift on September 13, 2024, afternoon shift on, November 09, 2022, and January 10, 2025, and for NOC shift on August 30-2022. No other documentation was provided. On February 18, 2025, at 2:30 p.m., LALD-A stated there were no additional documented drills for the facility and would implement a program	0 810		

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0 810	Continued From page 26 that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: During facility tour on February 18, 2025, from 1:00 p.m. to 3:00 p.m., with licensed assisted	0 830		

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0 830	Continued From page 27 living director (LALD)-A. At the time of the survey, the lower level of the home was under construction. Under MN Rules 1300.0120, An owner or authorized agent who intends to construct, enlarge, alter, repair, move, demolish, or change the occupancy of a building or structure, or to erect, install, enlarge, alter, repair, remove, convert, or replace any gas, mechanical, electrical, plumbing system, or other equipment, the installation of which is regulated by the code; or cause any such work to be done, shall first make application to the building official and obtain the required permit. On February 18, 2025, at 2:30 p.m., LALD-A stated the lower level was not being used by staff or residents, and they intended to remodel/finish the entire basement area but was unable to financially. This has left the entire basement in an unapproved and unsafe condition. No permits have been applied for with local officials and plans have not been submitted to MDH. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 830		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:	0 910		

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0 910	Continued From page 28 (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all of the licensee's residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On February 18, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-B provided the surveyor with a blank copy of the licensee's Assisted Living Contract via email. The blank copy of the contact contained the name, address, telephone number, and a section titled "Assisted Living License Number" followed by 404676. This license number was an expired license number that had been issued August 1, 2021, and was valid until July 31, 2022. The contract did not contain the licensee's health facility identification number (HFID) as required. On February 19, 2025, at 9:03 a.m., CNS-B	0 910		

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0 910	Continued From page 29 stated the contract was the same contract used for all residents and were not aware the licensee needed to include the licensee's HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 970		

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0 970	Continued From page 30 The findings include: On February 18, 2025, at 1:40 p.m., clinical nurse supervisor (CNS)-B provided the surveyor with a blank copy of the licensee's Assisted Living Contract via email. On February 19, 2025, at 9:03 a.m., CNS-B stated the contract was the same contract used for all residents. The licensee's Assisted Living Contract included the following language: - Page 14, in the section titled Indemnifications, "[name of licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [name of licensee] harmless from any claims or damages unless caused solely by negligence of [name of licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On February 19, 2025, at 9:15 a.m., CNS-B stated they were not aware the licensee's contract contained language that could be interpreted as a liability waiver. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=F	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 31 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for two of four employees (unlicensed personnel (ULP)-D, ULP-E). 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: ULP-D ULP-D was hired October 20, 2019, and began	01290		

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01290	Continued From page 32 providing assisted living services August 1, 2021. ULP-D's employee record contained a background study clearance dated December 23, 2019, affiliated to licensee's prior comprehensive home care license, HFID# 27490. This background study did not appear on the licensee's NetStudy 2.0 background study roster. ULP-D's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey. ULP-E ULP-E was hired April 12, 2021, and began providing assisted living services August 1, 2021. The licensee's NetStudy 2.0 background study roster indicated ULP-E's had a background study clearance dated November 17, 2017, affiliated to licensee's prior comprehensive home care license, HFID# 27490. ULP-E's record lacked evidence the licensee submitted a background study under the current assisted living license and affiliated to the current HFID number prior to the start of the survey. The licensee's Daily schedule for the week of February 16, indicated ULP-E was scheduled to work in an unsupervised capacity and February 21, and February 22, 2025. On February 18, 2025, at 1:38 p.m., clinical nurse supervisor (CNS)-B stated licensed assisted living director (LALD)-A was responsible for maintaining background checks for all staff within the facility. On February 19, 2025, at 12:09 p.m., LALD-A	01290		

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01290	Continued From page 33 stated on the licensee's previous licensing survey in 2022, they had gotten tagged for background checks and had gone through and updated all background checks. LALD-A stated they did not believe ULP-D had worked since this last survey. The licensee lacked policy and procedure for conducting and handling background studies on employees. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve	01500		

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01500	Continued From page 34 when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and 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 interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (clinical nurse supervisor (CNS)-B).	01500		

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01500	Continued From page 35 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: CNS-B was hired on September 15, 2015, and began providing assisted living services, clinical oversight, and supervision of unlicensed personnel on August 1, 2021. CNS-B's employee record lacked at least eight hours of annual training for each 12 months of employment in the following topics: - Reporting maltreatment of vulnerable adults or minors; - Assisted Living bill of rights; and - Infection control techniques. On February 19, 2025, at 2:48 p.m., CNS-B stated they were under the assumption Educare (training software program utilized by the licensee) would automatically provide everything that would be needed for annual training requirements. CNS-B stated they were still trying to figure it out. The licensee's undated annual trainings document indicated all staff that perform home care services must complete 8 hours of annual training for every 12 months of employment. Orientation may be included as part of the annual training requirement. The annual training must include the following:	01500		

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01500	Continued From page 36 - Training on reporting of maltreatment of vulnerable adults or minors; - Review of assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - Review of provider's policies and procedures and how to implement them; and - Infection control training which includes the following: - Hand washing techniques; - The need for and the use of protective gloves, gowns and masks; - Disposal of contaminated materials and equipment, such as dressings needles, syringes, and razor blades; - Reporting of communicable diseases; - Disinfecting reusable equipment; and - Disinfecting environmental surfaces. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days 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	01620		

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01620	Continued From page 37 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the RN conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 was admitted on May 29, 2022, to receive assisted living services. R2's diagnosis included anxiety disorder, ataxia, aphasia, polyneuropathy, migraines, history of hypotension, history of sepsis, and history of	01620		

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01620	Continued From page 38 acute hypoxemic respiratory failure. R2's unsigned Service Plan (Waiver) - Addendum to contract dated February 19, 2025, indicated R2 received assistance with activities, deep room cleaning, drinking assistance, incontinence care, and medication administration. R2's record contained 90-day assessments dated June 12, 2024, and November 9, 2024, which indicated 150 days had lapsed between R2's assessment dates. R3 R3 was admitted on September 8, 2023, to receive assisted living services. R3's diagnosis included hyperacusis (a condition resulting in a reduced tolerance to sound), ataxia (a condition resulting in the loss of muscle control in the arms and legs which may lead to lack of balance), developmental disabilities, depression, anxiety, PPD, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder and aphasia (a disorder which affects the ability to speak). R3's unsigned Service Plan (Waiver) - Addendum to contract dated February 19, 2025, indicated R3 received assistance with activities, assistance with appointment reminders, dressing, grooming, housekeeping, incontinence care, escort and mobility assistance, laundry, linen changes, behavior management, medication administration, and care of respiratory equipment. R3's record contained 90-day assessments dated March 17, 2024, and November 14, 2024, which indicated 243 days had lapsed between R3's assessment dates.	01620		

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01620	Continued From page 39 On February 19, 2025, at 2:58 p.m., clinical nurse supervisor (CNS)-B stated the licensee had transitioned from paper documentation to computer documentation during the time frame in which R2 and R3 were missing assessments. CNS-B stated they believed assessments had been completed for R2 and R3 but were unable to locate them. The licensee's undated Initial Nursing Assessment, Reassessment, and Focused Assessment document indicated a resident nursing reassessment must be conducted in the individual's residence no more than 14 days after services are first provided, every 90 days or more frequently based on changes in the needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for	01640		

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	36630	A. BUILDING: _____ B. WING _____	02/20/2025

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01640	Continued From page 40 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure current service plans included a signature or other authentication by the resident to document agreement on the services to be provided for all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 19, 2025, at 9:22 a.m., clinical nurse supervisor (CNS)-B stated they were not aware service plans needed to be signed. CNS-B stated they were under the assumption that when contracts were signed, the signature extended to the service plan. CNS-B stated there would be no signed service plans for any residents. On February 19, 2025, at 9:27 a.m., licensed	01640		

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01640	Continued From page 41 assisted living director (LALD)-A stated the licensee did not obtain signatures on service plans. Additionally, LALD-A asked the surveyor for guidance on who would need to sign the service plan, which demonstrated a general lack of knowledge on the requirement. On February 19, 2024, at approximately 10:00a.m., the surveyor requested copies of the unsigned service plans for review. On February 19, 2024, at 10:23 a.m., the surveyor observed CNS-B call R-tasks (a web based online medical documentation system) to ask for assistance and access to service plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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 practice resulted in a level two violation (a	01880		

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01880	Continued From page 42 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 19, 2025, from 7:27a.m. to 7:56 a.m., the surveyor observed clinical nurse supervisor (CNS)-B administer medications to residents residing within the facility. At 7:27 a.m., the surveyor observed CNS-B unlock the licensee's medication storage cart, which was positioned directly adjacent to the licensee's kitchen, and then leave medication cart unlocked and unattended to wash hands in the kitchen sink on the other side of the kitchen. After preparing medications, the surveyor observed CNS-B leave the licensee's medication storage cart unlocked and unattended from 7:30 a.m., to 7:35 a.m., to administer medications to R2, from 7:46 a.m., to 7:51 a.m., to administer medications to R3, and again from 7:53 a.m. to 7:55a.m., to administer medications to R4. On February 19, 2025, at 8:37 a.m., CNS-B stated they should have secured the medication cart in between all medication passes, and they were very nervous due to the survey process. The licensee's undated Storage and Security of Medications document indicated all medications were kept locked at all times except when being prepared for administration, and only the person authorized to administer medications would have access to the medications.	01880		

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01880	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were kept in the original container in which dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug as well as disposing of expired medications. This had a potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	01890		

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01890	Continued From page 44 On February 19, 2025, at 8:09 a.m., during an audit of the licensee's medication storage cart the surveyor observed the following unidentified medications stored outside of their original container: - a small plastic pouch containing 12 unidentified white capsules with marking of OME 20; - one small white capsule with a light green stripe found in the second drawer of the medication storage cart; - one light gray round tablet found in the second drawer of the medication storage cart; - one white round tablet found in the second drawer of the medication storage cart; - two small white round tablets in the second drawer of the medication storage cart; - one small round, light pink tablet found in the second drawer of the medication cart; - one large red round tablet in found in the second drawer of the medication cart; - one half of large white tablet found in the back right corner of the of the bottom drawer of the medication cart; - one light pink oval tablet found in the back right corner of the of the bottom drawer of the medication cart; - one blue and white capsule found in the back right corner of the of the bottom drawer of the medication cart; - one blue and white capsule found in the front right corner of the of the bottom drawer of the medication cart; - one small round light pink tablet found in the front right corner of the of the bottom drawer of the medication cart; - one small round white tablet found in the front right corner of the of the bottom drawer of the medication cart, and; - one small white oval tablet found in the front	01890		

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01890	Continued From page 45 right corner of the of the bottom drawer of the medication cart. In addition to the loose pills discovered in the medication cart, the surveyor observed a large amount of yellow and white granular substance in the corners of all medication drawers. The surveyor asked clinical nurse supervisor (CNS)-B what the substance was. CNS-B stated the granular substance was likely Depakote sprinkles (anticonvulsant medication) that had fallen into the drawer during set up of medications for residents residing within the facility. On February 19, 2025, at 8:09 a.m., during an audit of the licensee's medication storage cart the surveyor also observed the following expired medications: - quetiapine 25 milligrams (mg) tablets belonging to R2 with an expiration date of April 4, 2023; and, - escitalopram 20mg tablets belonging to R2 with an expiration date of September 30, 2024. On February 19, 2025, at 8:17 a.m., CNS-B stated they were in charge of managing the medication carts. CNS-B stated that loose medications should be disposed of when discovered, and expired medications should also be disposed of. CNS-B did not provide the surveyor with rationale for the lack of maintenance but stated they would clean up the medication cart immediately. The licensee's undated Storage and Security of Medications document indicated all medication ordered for a specific resident will be kept in a container bearing the original prescription label with legible information including the expiration or beyond use date.	01890		

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01890	Continued From page 46 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=G	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 one of two residents (R3) who utilized 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on September 8, 2023, to receive assisted living services. R3's diagnosis included hyperacusis (a condition resulting in a reduced tolerance to sound), ataxia	02310		

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02310	Continued From page 47 (a condition resulting in the loss of muscle control in the arms and legs which may lead to lack of balance), developmental disabilities, depression, anxiety, PPD, obsessive-compulsive disorder, attention-deficit/hyperactivity disorder and aphasia (a disorder which affects the ability to speak). R3's unsigned Service Plan (Waiver) - Addendum to contract dated February 19, 2025, indicated R3 received assistance with activities, assistance with appointment reminders, dressing, grooming, housekeeping, incontinence care, escort and mobility assistance, laundry, linen changes, behavior management, medication administration, and care of respiratory equipment. On February 18, 2025, at 11:05 a.m., during a tour of the facility, the surveyor observed a hospital style bed with bed rails in the upright position on both sides of the upper part of the bed. R3's record included a 90-day assessment dated January 24, 2025, which indicated that due to their neurodegenerative disorder and ataxia, R3 required a one-person pivot transfer when getting in and out of bed and was wheelchair dependent. The assessment also included an assessment of R3's bed rails. The bed rail assessment included the purpose and intention of the bed rail and the residents bed rail use and need assessment. The bed rail assessment lacked the following required contents: - measurements of entrapment zones; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct	02310		

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02310	Continued From page 48 installation; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. On February 19, 2025, at 1:39 p.m., the surveyor observed CNS-B perform an assist of one pivot transfer with R3 from their wheelchair into a recliner using gait belt. After being placed in the recliner, the surveyor observed R3 losing balance while sitting several times, which required hands on assistance from staff to prevent R3 from falling out of their recliner. On February 20, 2025, at 2:09 p.m., CNS-B provided a document titled Bed Rail Compliance Report for R3 dated November 26, 2024. The form contained the following: - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. Additionally, R3's Bed Rail Compliance Report contained a table which listed numbered zones of entrapment, descriptions of zones, required dimensions of zones, measured zones (measured by the licensee), and a place to indicate whether the zones were compliant. The form indicated the following: Zone 1: Description: Within Rail; Required Dimension: less than or equal to 4.75 inches; Measured Dimension: measured at 4.8 inches, and an indication of compliance was circled yes. Zone 2: Description: Under the rail between	02310		

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02310	Continued From page 49 supports; Required Dimension: less than or equal to 4.75 inches; Measured Dimension: measured at 4.9 inches, and an indication of compliance was circled yes. Zone 3: Description: Between the rail and the mattress; Required Dimension: less than or equal to 4.75 inches; Measured Dimension: measured at 5.1 inches, and an indication of compliance was circled yes. Zone 4: Description: Under the rail at the end; Required Dimension: less than or equal to 2.375 inches; Measured Dimension: measured at 5 inches, and an indication of compliance was circled yes. On February 20, 2025, at 3:12 p.m., licensed assisted living director (LALD)-A stated they believed the entrapment zones were to be measured as greater than or equal to the required dimensions listed on the assessment form. Additionally, LALD-A stated they did not believe this bed rail could be out of compliance as it was a standard hospital bed rail. R3's Bed Rail Compliance Report indicated the zones of entrapment were outside of the recommended measurements but were documented as being in compliance. The licensee failed to recognize the documented measurements exceeded the maximum dimensional limit allowed, therefore R3's record lacked any necessary information to mitigate the safety risks. The Food and Drug Administration's (FDA), Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, indicated Zone 1 is any open space within the perimeter of the rail. Openings in the rail should	02310		

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02310	Continued From page 50 be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space. The Hospital Bed Safety Workgroup (HBSW) and International Electrotechnical Commission (IEC) recommend that the space be less than 120 mm (4 ¾ inches), representing head breadth. Zone 2 is the space is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at a location between the rail supports, or next to a single rail support. The FDA recommends that this space be small enough to prevent head entrapment, less than 120 mm (4 ¾ inches). Zone 3 is the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The FDA recommends a dimensional limit of less than 120 mm (4 ¾ inches) for the area between the inside surface of the rail and the compressed mattress. Zone 4 is the gap that forms between the mattress compressed by the patient, and the lowermost portion of the rail, at the end of the rail. The FDA recommends that the dimensional limit for this space also be less than 60 mm (2 3/8 inches). The FDA's, A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."	02310		

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02310	Continued From page 51 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". In addition, the MDH website indicated, "licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information." No further information was provided.	02310		

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02310	Continued From page 52 TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Type: Full
Date: *02/18/25*
Time: 12:35:41
Report: 1004251044

Food and Beverage Establishment Inspection Report

Location:

Royal Age Assisted Living Llc
7047 Goodview Avenue South
Cottage Grove, MN55016
Washington County, 82

Establishment Info:

ID #: 0039238
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514580343
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

EMPLOYEE ILLNESS LOG COULD NOT BE PRODUCED DURING INSPECTION. ENSURE ALL EMPLOYEE REPORTS OF GASTROINTESTINAL SYMPTOMS AND ILLNESSES THAT CAN BE PASSED THROUGH FOOD ARE RECORDED AND THAT THE LOG IS PRODUCED PER REQUEST. LOG PROVIDED WITH REPORT.

Comply By: 02/18/25

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

REPEAT ORIGINALLY ISSUED 7/20/22. REISSUED 2/19/25:RAW SHELL EGGS FOUND STORED OVER READY-TO-EAT ITEMS AND PRODUCE IN THE KITCHEN REFRIGERATOR. DISCUSSED STORAGE ORDER REQUIREMENTS AND OPERATOR MOVED EGGS TO LOWEST DRAWER DURING INSPECTION.

Comply By: 07/20/22

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

RESIDENTIAL KITCHEN DISH MACHINE IS NOT REACHING A MINIMUM REQUIRED UTENSIL SURFACE TEMPERATURE OF 160*F. UNTIL UNIT IS REPAIRED/REPLACED, ESTABLISHMENT WILL BE MANUALLY SANITIZING ALL DISHES WITH A CHLORINE SOLUTION.

Comply By: 02/18/25

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

MULTIPLE OPEN PACKAGES OF TCS FOOD ITEMS (DELI HAM, HOT DOGS) FOUND IN THE REFRIGERATOR WITHOUT DATE MARKING. ENSURE ALL COLD, TCS ITEMS ARE CLEARLY DATE MARKED WHEN OPENED AND ENSURE THEY ARE CONSUMED OR DISCARDED WITHIN 7 DAYS.

Comply By: 02/18/25

4-300 Equipment Numbers and Capacities

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

THERMOMETER PRODUCED ON SITE IS NOT FUNCTIONING. ENSURE A FUNCTIONING THERMOMETER IS PRESENT AND IN USE.

Comply By: 02/18/25

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

REPEAT ORIGINALLY ISSUED 7/20/22: FACILITY'S DISH MACHINE USES HOT WATER TO SANITIZE WARE. NO TEST KIT MEETING ABOVE REQUIREMENT WAS AVAILABLE. COMPLY WITH ABOVE RULE. REISSUED 2/18/25: DISCUSSED OPTIONS WITH OPERATOR AND LEFT THERMOLABELS ON SITE.

Comply By: 07/27/22

4-300 Equipment Numbers and Capacities

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

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

REPEAT ORIGINALLY ISSUED 7/20/22: CHLORINE SANITIZER IS MIXED ON SITE. TEST KIT PROVIDED DURING INSPECTION WAS FOR POOLS/SPAS AND IS NOT EFFECTIVE FOR USE WITH FOOD-CONTACT SURFACE SANITIZING. PROVIDE CORRECT KIT AND USE FREQUENTLY. REISSUED 2/18/25.

Comply By: 07/27/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C ***** Priority 2 *****

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.

MOUSE TRAPS FOUND STORED ON THE KITCHEN COUNTERS. REMOVE FROM COUNTERTOPS AND PROVIDE APPROVED TRAPPING/REPELLENT DEVICES. *TRAPS WERE REMOVED DURING INSPECTION.

Comply By: 02/18/25

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

REPEAT ORIGINALLY ISSUED 7/20/22: NO MN CFPM WAS EMPLOYED AT THE FACILITY. THE OPERATOR HAS COMPLETED A FOOD SAFETY COURSE BUT DID NOT APPLY WITH THE STATE FOR STATE CERTIFICATION. INFORMATION PROVIDED WITH REPORT. REISSUED 2/18/25.

Comply By: 10/17/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO INTERNAL THERMOMETER LOCATED IN THE REFRIGERATOR. ESTABLISHMENT HAS A CONTINUOUS MONITORING DEVICE FOR THE REFRIGERATOR THAT PRODUCES A DIGITAL LOG, BUT DOES NOT HAVE IT INSTALLED. PROVIDE AND MAINTAIN.

Comply By: 02/18/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

DISH MACHINE IS NOT REACHING REQUIRED MINIMUM UTENSIL SURFACE TEMPERATURE FOR SANITIZING. REPAIR/REPLACE MACHINE AND ENSURE A MINIMUM OF 160*F IS REACHED FOR UTENSIL SURFACE TEMPERATURE.

Comply By: 02/18/25

4-600 Cleaning Equipment and Utensils

4-602.13

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

REPEAT ORIGINALLY ISSUED 7/20/22: GRIME AND BUILD UP WERE ON THE CABINET HANDLES AND DOORS LOCATED IN THE KITCHEN. GRIME AND FOOD DEBRIS/SPLATTER WAS FOUND ON THE MICROWAVE, OVEN, AND DISHWASHER. CLEAN AND MAINTAIN CLEAN. REISSUED 2/18/25.

Comply By: 07/20/22

Type: Full
Date: *02/18/25*
Time: 12:35:41
Report: 1004251044
Royal Age Assisted Living Llc

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 150 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: HAM
Temperature: 38 Degrees Fahrenheit - Location: REFIRGERATOR
Violation Issued: No

Process/Item: HOT DOG
Temperature: 37 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: CUT LETTUCE
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	3	5	4

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY ZACHARY MORTH.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-LOGS (REFRIGERATOR TEMPERATURE)
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE OPERATOR, MTHUNZI, AND WITH THE NURSE EVALUATOR, ZACHARY.

*ESTABLISHMENT WILL BE MANUALLY SANITIZING ALL DISHES UNTIL DISH MACHINE IS REPAIRED AND VERIFIED TO BE REACHING A MINIMUM UTENSIL SURFACE TEMPERATURE OF 160*F. DISCUSSED MANUAL SANITIZING PROCEDURES WITH THE OPERATOR.

*FLOORS ARE WOOD AND CEILING IS "POPCORN" TEXTURE. COUNTERTOPS ARE GRANITE AND CABINETS ARE VARNISHED WOOD WITH HALLOW BASE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A

TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

*KITCHEN HAS A 2-BASIN SINK. ONE BASIN IS DESIGNATED AS THE HANDWASHING SINK. THIS BASIN MAY ONLY BE USED FOR HANDWASHING PURPOSES.

*THERE IS A RESIDENT DOG ON SITE. OPERATOR STATED THAT THE DOG IS NOT ALLOWED INTO THE KITCHEN AREA. DISCUSSED REQUIREMENT OF PREVENTING THE DOG FROM ENTERING THE KITCHEN.

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

INSPECTOR WILL FOLLOW-UP WITH ESTABLISHMENT TO ENSURE DISH MACHINE IS VERIFIED TO BE MEETING MINIMUM REQUIRED UTENSIL SURFACE TEMPERATURE FOR SANITIZING DISHES

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 1004251044 of 02/18/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____

MTHUNZI DEWA
OPERATOR

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us