Electronically Delivered

July 25, 2023

Licensee
Arbor Lane
13810 Community Drive
Burnsville, MN 55337

RE: Project Number(s) SL30765015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 15, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

Please address your cover letter for reconsideration requests to:

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

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,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30765	A. BUILDING: _____ B. WING _____	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LANE	13810 COMMUNITY DRIVE BURNSVILLE, MN 55337

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30765015-0 On June 12 through June 15, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 40 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated June 12, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510		

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0 510	Continued From page 2 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure proper cleaning of shared assistive devices after use, between residents for 2 of 3 residents (R10, R11). Further the licensee failed to ensure direct care staff performed adequate hand hygiene (HH) for 1 of 3 observed staff (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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-D, and ULP-I were hired January 16, 2023, and June 21, 2013, respectively, and provided direct care services for residents. CLEANING SHARED EQUIPMENT R10 had diagnoses including Alzheimer's	0 510		

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0 510	Continued From page 3 dementia, and received services including assistance with medication management, transfers, housekeeping and laundry. R11 had diagnoses including dementia, and received services including assistance with medication management, transfers, housekeeping and laundry. On June 12, 2023, at 1:45 p.m., during surveyor observation, ULP-I moved R11 in her wheelchair from the memory care shared space to R11's apartment. ULP-I assisted R11 with the transfer from R11's wheelchair to the toilet, using the shared sit-to-stand (medical device that helps resident transfer from sitting position to standing position) mechanical lift device. During R11's sit-to-stand transfer, surveyor observed the footboard of the sit-to-stand had areas of crusted dark brown colored material on the base and edges. In addition, there were no cleaning wipes on or near the sit-to stand. ULP-I did not clean the sit-to-stand before she exited R11's apartment. On June 12, 2023, at 2:00 p.m., ULP-D went into R11's apartment and retrieved the shared sit-to stand. ULP-D brought the sit-to-stand to R10's apartment. ULP-D did not clean the sit-to-stand before entering R10's apartment. ULP-D used the sit-to stand to assist R10 to transfer from wheelchair to the bathroom for toileting cares. After R10's cares were provided, ULP-D transferred R10 back into the wheelchair using the sit-to-stand, and ULP-D placed the sit-to stand back into R10's bathroom to be stored. ULP-D exited R10's apartment without cleaning the sit-to-stand. On June 12, 2023 at 2:22 p.m., after the surveyor	0 510		

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0 510	Continued From page 4 asked ULP-D how often the sit-to-stand was cleaned, ULP-D did not answer, and proceeded to walk to the memory care kitchen area, and ULP-D obtained cleaning wipes. ULP-D donned gloves, and wiped down the sit-to stand lift with the cleaning wipes. ULP-D stated, "I will clean it between each resident." ULP-D confirmed she was trained to clean equipment between each residents' use. On June 12, 2023, at 2:55 p.m., ULP-I stated the shared sit-to-stand equipment was cleaned on the night shift. On June 14, 2023, at 1:04 p.m., clinical nurse supervisor (CNS)-B indicated all medical device equipment used by the resident's were scheduled to be cleaned weekly and should be documented on the resident service check off list. CNS-B stated, this was an area that needed to be focused on. The United States (U.S.) Food and Drug Administration (FDA) undated document titled Patient Lifts Safety Guide, on page 15 included, "Follow manufacturer instructions to clean and disinfect lift. Always clean lift before and after each patient use." The sit-to stand manufacturer's resource titled, EZ Way Equipment Cleaning Guide, dated February 26, 2021, included "To keep your EZ Way equipment clean and in good condition, we recommend that you use a standard germicidal spray, Sani-Wipe, or similar product and that you follow these guidelines: - DO NOT SPRAY PRODUCT DIRECTLY ON THE MACHINE. · Spray the cleaner onto a cloth or paper towel then wipe the unit to clean it.	0 510		

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0 510	Continued From page 5 · The germicidal spray, Sani-Wipe, or similar product can be used on the control panel and front panel graphics. If not using a wipe, make sure to spray the cleaner onto a cloth or paper towel then wipe the unit to clean it. · Be careful not to wipe off the model and serial number sticker (located on the side of the mast, on floor lifts and sit-to-stands.)" The licensee's Standing Lift Assist policy, dated September 1, 2021, indicated "Clean with appropriate sanitizing product after use." HAND HYGIENE R4 had diagnoses including vertebral fracture, and received services including assistance with medication management, meals, transfers, housekeeping and laundry. On June 12, 2023, at 4:00 p.m., ULP-D assisted R4 to transfer from the bed to the wheelchair using a sit-to-stand assisted lift device. ULP-D knocked and entered R4's room. ULP-D turned the bathroom faucet on, appeared to dispense soap into her hands, then rubbed hands together under the running water for 6 seconds, dried, turned faucet off with paper towel, and donned gloves. ULP-D transferred R4 from her bed into the wheelchair using the sit-to-stand device. ULP-D then removed her gloves and without using soap, rinsed her hands under running water for 5 seconds, dried, then turned the water off with paper towel. ULP-D then pushed R4 down the hallway into the dining area and up to a table for dinner. ULP-D stated she would next be going to get another resident for dinner. On June 12, at 4:20 p.m., ULP-D stated she had	0 510		

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0 510	Continued From page 6 HH training when hired. ULP-D stated she was sometimes rushed and did not wash hands for as long as she should. ULP-D added the soap dispenser in R4's room was not working, so no soap was available to use. On June 13, 2023, at 7:15 a.m., ULP-E was observed assisting R4 with activities of daily living (ADLs), catheter care, and transfer from bed to wheelchair. ULP-E attempted to perform HH using soap and water, and demonstrated to surveyor the soap dispenser in R4's room was still not functioning. ULP-E unlocked a cabinet in R4's kitchen, retrieved a small bottle of hand soap and set it on the sink in R4's bathroom. ULP-E proceeded to perform appropriate HH during and after assisting R4 with cares. On June 14, 2023, at 1:00 p.m., CNS-B stated staff HH audits were recently scheduled to be completed, but the nurse that was assigned to do them left employment with the licensee. CNS-B stated staff were trained to perform HH with soap and water for 20 seconds between performing cares for residents, before donning and after doffing gloves. The CDC guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated, standard precautions were to be used to care for all patients in all settings to include HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices	0 510		

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0 510	Continued From page 7 c. Before moving from work on a soiled body site to a clean body site on the same patient d. After touching a patient or the patient's immediate environment e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." The licensee's Hand Washing Procedure policy, revised November 15, 2019, indicated hands should be washed before and after any resident contact, and after removal of gloves. The policy indicated handwashing instructions including, "Obtain soap from dispenser. Lather well. Vigorously wash hands for 20 seconds." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;	0 730		

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0 730	Continued From page 8 (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for one of four residents (R2) with records reviewed. This practice resulted in a level two violation (a	0 730		

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0 730	Continued From page 9 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: R2's medical record lacked documentation of services received, including safety checks for a period of ten hours. R2's diagnoses included dementia, type 2 diabetes, hypertension (high blood pressure), and depression. R2's service plan dated January 6, 2023, indicated R2 received services including assistance with meals, bathing, toileting, dressing, grooming, transfers, safety checks, TED hose (compression stockings), laundry, blood glucose testing, and medication administration. R2's documentation of services, titled "service check-off list" dated June 1, 2023, through June 12, 2023, identified services including scheduled safety checks to be performed every two hours. R2's "service check off list" lacked the following documentation for June 5, 2023: -safety checks at 4:00 p.m., 6:00 p.m., 8:00 p.m., and 10:00 p.m. On June 14, 2023, at 1:30 p.m., clinical nurse supervisor (CNS)-B stated, she was not sure why the safety checks were not documented. In addition, CNS-B agreed this was a safety concern and all caregivers were trained to document all	0 730		

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0 730	Continued From page 10 services provided. The licensee's Client Record policy, revised August 1, 2021, included "Client records will contain documents and information to comply with the Minnesota Assisted Living license and other regulatory requirements." In addition,"Record entries will be legible, permanently recorded, dated, and signed by the person making the entry." Additionally, "Documentation that services have been provided as identified in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.	0 800		

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0 800	Continued From page 11 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). Findings include: On a facility tour on June 15, 2023, at approximately 11:00 a.m. with licensed assisted living director (LALD)-A, regional director of facilities (RDF)-R, environmental services director (ESD)-T and environmental services director (ESD)-S it was observed that a fire-resistant rated door was broken where the door closer attaches in the fire rated stairway enclosure on first floor near the Seedlings classroom of the childcare/ adult day services area. Fire resistant rated doors are required to be maintained as designed and installed. It was also observed that the fire-resistant rated door in the first-floor exit stairway near the Seedlings classroom would not close and latch fully because of the magnetic locking device. Fire resistant rated doors are required to fully close and latch to protect the stairway from fire in the event of a fire emergency. On the same facility tour it was observed the fire resistant rated double corridor doors near the childcare director's office were cut and notched in order to install magnetic locking system on the doors. Fire resistant rated doors are required to be maintained as designed and installed and shall not be altered.	0 800		

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0 800	Continued From page 12 It was also observed that the fire-resistant rated double corridor doors near the childcare director's office would not close and latch fully because of the magnetic locking device. Fire resistant rated doors in fire resistant rated walls are required to fully close and latch to protect the areas on either side of the doors from fire in the event of a fire emergency. It was also observed an exterior exit gate from the secure outdoor recreation area in childcare/ adult day services was provided with a fence gate type latch. Gates or doors in the exterior exit path to the public way are required to operate with hardware on the interior of the gate, the same as the building exterior exit doors. These deficient conditions were visually verified by LALD-A, RDF-R, ESD-S and ESD-T accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30765	A. BUILDING: _____ B. WING _____	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LANE	13810 COMMUNITY DRIVE BURNSVILLE, MN 55337

(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
01620	Continued From page 13 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 registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after admission for three of four residents (R3, R4, R5), and not more than 90 days from the previous assessment for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: 14-DAY R3 R3 was admitted March 15, 2022, and received services including assistance with meals,	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30765	A. BUILDING: _____ B. WING _____	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LANE	13810 COMMUNITY DRIVE BURNSVILLE, MN 55337

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01620	Continued From page 14 transfers, safety checks, showers, dressing, grooming, laundry, tube feedings, and medication administration. R3's record included an initial assessment completed March 15, 2022, and a subsequent assessment completed June 17, 2022, greater than 14 days after R3 started receiving services. R4 R4 was admitted February 7, 2022, and received services including assistance with meals, transfers, catheter care, laundry, housekeeping, and medication management. R4's record included an initial assessment completed February 8, 2022, and a subsequent assessment completed February 28, 2022, greater than 14 days after R4 started receiving services. R5 R5 was admitted October 26, 2022, and received services including assistance with meals, transfers, toileting, wound care, housekeeping, and medication management. R5's record included an initial assessment completed October 26, 2022, and a subsequent assessment completed November 14, 2022, greater than 14 days after R5 started receiving services. 90-DAY R2 was admitted September 14, 2018, and received services including assistance with meals, bathing, toileting, dressing, grooming, transfers, safety checks, TED hose (compression stockings), laundry, blood glucose testing, and	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30765	A. BUILDING: _____ B. WING _____	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LANE	13810 COMMUNITY DRIVE BURNSVILLE, MN 55337

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01620	Continued From page 15 medication administration. R2's record included a comprehensive nursing assessment dated July 12, 2022, and an assessment dated November 16, 2022, 37 days after the 90-day assessment was due to be completed. Further, R2's record included a subsequent assessment completed March 15, 2023, 29 days after the 90-day assessment was due. On June 13, 2023, at approximately 3:00 p.m., clinical nurse supervisor (CNS)-B provided requested assessments for R2, R3, R4, and R5 and indicated on the written request form no additional assessments were available. On June 14, 2023, at 1:07 p.m., CNS-B stated the nurse responsible for the assessments was no longer employed by the licensee. They were aware many assessments were delinquent and she was working to make them all current. CNS-B was not aware the initial reassessment was due within 14 days of start of services, rather than 14-30 days. CNS-B further stated they were now tracking upcoming assessments with a report, and the assessments would be scheduled for the nurse to complete. The licensee's Assessment of Clients-Initial and Ongoing policy, revised August 1, 2021, indicated, "Resident reassessment and monitoring will be conducted no more than 14 calendar days after initiation of services. Ongoing client reassessment and monitoring will be conducted as needed, based on changes in the needs of the client and not to exceed 90 calendar days from the client's last date of the uniform assessment."	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30765	A. BUILDING: _____ B. WING _____	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LANE	13810 COMMUNITY DRIVE BURNSVILLE, MN 55337

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01620	Continued From page 16 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were transcribed as prescribed for one of four 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 situation has occurred only occasionally).	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30765	A. BUILDING: _____ B. WING _____	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR LANE	13810 COMMUNITY DRIVE BURNSVILLE, MN 55337

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01760	Continued From page 17 The findings include: R3's diagnoses included Barrett's esophagus (abnormal changes in the tube that carries food to the stomach) with dysphasia (difficulty swallowing), anemia (low red blood cell count), and gastroesophageal reflux disease (GERD). R3's signed service plan agreement dated March 16, 2023, indicated R3 received medication management services to include medication administration three times a day. On June 12, 2023, at 3:59 p.m., unlicensed personnel (ULP)-J was observed to administer R3's scheduled afternoon medications. R3's record included a physician order dated May 3, 2023, for loratadine (for allergy symptoms) 10 milligrams (mg) tablet, take one tablet per feeding tube, once daily for four weeks, then as needed (PRN). R3's medication administration record (MAR) dated May 15, through June 13, 2023, included loratadine 10 mg, take one tablet per feeding tube once daily at 7:00 a.m. The start date for R3's loratadine documented on the MAR was May 5, 2023. R3's MAR lacked an end date after four (4) weeks of loratadine (June 2, 2023), and also lacked a subsequent PRN order on the MAR, per the provider order. R3 continued to receive loratadine 10 mg daily through June 13, 2023, 10 days beyond the prescribed order. On June 14, 2023, at 2:05 p.m., clinical nurse supervisor (CNS)-B, confirmed R3's MAR was not transcribed correctly into the electronic medical record (EMR). CNS-B stated this would	01760		

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01760	Continued From page 18 be considered a medication error, and added family and physician were notified. Further, CNS-B stated the MAR for R3 had been corrected and a medication error incident report were completed during the survey. The licensee's Medication Management Services policy, revised August 1, 2021, included "Verifying that prescription drugs are administered as prescribed." The licensee's Medication and Treatment Implementation policy, revised August 1, 2021, included "The RN will update any client records and service plan as necessary to reflect a new order or prescription." Also included "2. Upon receipt of a prescription or order from an authorized prescriber, the RN must take action to implement the order within an appropriate time frame based on the needs of the client and the professional judgment of the RN. These actions include: a. Adding the order or prescription to the client record in the appropriate place and updating the service plan, care plan, medication record/MAR or other documents as necessary to reflect any changes in prescriptions or orders. The RN must include in the client's record written instructions for staff to follow when implementing the new order or prescription." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies	01950		

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01950	Continued From page 19 must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure training and competency evaluations were completed as required prior to providing direct care to residents for two of four employees (unlicensed personnel (ULP)-J, ULP-N). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 20 ULP-J and ULP-N were hired on May 2, 2022, and May 5, 2020, respectively, and provided assisted living services to residents. ULP-J and ULP-N's employee records lacked documentation of training and competency evaluation for enteral (delivered into the digestive system) nutrition, feeding tube medication administration, and enteral feeding tube irrigation. On June 12, 2023, from 3:59 p.m. to 4:30 p.m., ULP-J was observed to provide cares and services for R3 which included enteral feeding tube irrigation, feeding tube medication administration, and enteral tube feeding. R3's medication administration record (MAR) dated June 15, 2023, through June 31, 2023, indicated both ULP-J and ULP-N provided enteral feeding tube irrigation, feeding tube medication administration, and enteral tube feeding's to R3 as documented on MAR: -ULP-J: June 17, June 20, June 22, June 24-26, and June 30-31, 2023, (4:00 p.m.); and -ULP-N: June 20, June 25, and June 26, 2023, (7:00 a.m.). On June 12, 2023, at 5:19 p.m., licensed assisted living director (LALD)-A stated, the training and competencies were not found in ULP-J's record. In addition, LALD-A stated a registered nurse (RN), who no longer worked here, may have trained ULP-J, or the clinical nurse supervisor (CNS)-B. LALD-A indicated she was unable to find the competency documentation. On June 13, 2023, at 9:31 a.m., LALD-A stated all employees had the competency documentation for feeding tubes in their record, except ULP-J.	01950		

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01950	Continued From page 21 On June 13, 2023, at 10:50 a.m., LALD-A stated, she did not know how ULP-N's training and competency were missed or where the documentation is located. The licensee's Delegation of Nursing Services - Treatments policy, revised August 1, 2021, included "Before delegating or assigning a task to unlicensed personnel, the RN must determine that each staff member who will perform the task is trained and competent to perform the task and has been instructed in the proper procedures for performing the procedures with respect to the specific client." Additionally, "The Director of Health Services (DHS) will assure that training and competency records for all unlicensed staff are kept up-to-date and are easily accessible to the RN so that the RN can determine which staff is competent to perform various delegated tasks." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

DEPARTMENT OF HEALTH

Type: Full
Date: *06/12/23*
Time: 11:00:00
Report: 1036231149

Food and Beverage Establishment Inspection Report

Location:
Arbor Lane
13810 Community Drive
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0037979
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9528983288
ID #:

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114D ***** Priority 1 *****

MN Rule 4626.0805D Provide and maintain an approved other solution of a chemical that achieves sanitization as defined in 4626.0020 subpart 75.

ECOLAB SMARTPOWER SANITIZER MEASURED 0 PPM ON THE 1ST AND 3RD FLOOR DURING INSPECTION, ADVISED TO USE DISPENSER FROM 2ND FLOOR FOR ALL SANITIZER SOLUTIONS.

Comply By: 06/15/23

4-300 Equipment Numbers and Capacities

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

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

NO ECOLAB SMARTPOWER S&S TEST STRIPS AVAILABLE FOR TESTING SANITIZER CONCENTRATION. PROVIDE AND MAINTAIN.

Comply By: 06/19/23

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.

THE DELFIELD JUICE COOLER ON THE 3RD FLOOR HAS GASKET SEALS THAT ARE DETERIORATING. REPLACE AND MAINTAIN.

Type: Full
Date: *06/12/23*
Time: 11:00:00
Report: 1036231149
Arbor Lane

Food and Beverage Establishment Inspection Report

Comply By: 06/26/23

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 170.6 Degrees Fahrenheit
Location: HOT WATER DISH MACHINE
Violation Issued: No

UTENSIL SURFACE TEMP: = at 165.8 Degrees Fahrenheit
Location: HOT WATER DISH MACHINE
Violation Issued: No

UTENSIL SURFACE TEMP: = at 167.2 Degrees Fahrenheit
Location: HOT WATER DISH MACHINE
Violation Issued: No

LACTIC ACID & DDBSA: = 0 PPM at Degrees Fahrenheit
Location: SANI DISPENSER 1ST FLOOR
Violation Issued: Yes

LACTIC ACID & DDBSA: = 704/27 at Degrees Fahrenheit
Location: SANI DISPENSER 2ND FLOOR
Violation Issued: No

LACTIC ACID & DDBSA: = 0 PPM at Degrees Fahrenheit
Location: SANI DISPENSER 3RD FLOOR
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Ambient Temp
Temperature: 35 Degrees Fahrenheit - Location: 1ST FLOOR ARCTIC AIR COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 37 Degrees Fahrenheit - Location: 2ND FLOOR NORLAKE COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: 2ND FLOOR DELFIELD COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: 2ND FLOOR DELFIELD COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 38 Degrees Fahrenheit - Location: 3RD FLOOR NORLAKE COOLER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 40 Degrees Fahrenheit - Location: 3RD FLOOR DELFIELD COOLER
Violation Issued: No

Type: Full
Date: *06/12/23*
Time: 11:00:00
Report: 1036231149
Arbor Lane

Food and Beverage Establishment Inspection Report

Process/Item: Ambient Temp
Temperature: 4 Degrees Fahrenheit - Location: 2ND FLOOR DELFIELD FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -3 Degrees Fahrenheit - Location: 1ST FLOOR SINDLE DOOR FREEZER
Violation Issued: No

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

Announced inspection. Renee Anderson was the lead RN with HRD completing the site survey. Inspection conducted with CFPM Penny Flitsch.

Discussed the following with CFPM:
Employee illness policy and logging requirements
Glove-use
Handwashing procedure
No bare hand contact with ready to eat food
Thermometer use/calibration
Proper food storage
Sanitizing procedures for food contact surfaces
Fully cooking food for high risk populations
Violations on this report

*UPDATE 6/15/23: ECOLAB HAS CALIBRATED ALL SANITIZER DISPENSERS

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

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

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

I acknowledge receipt of the inspection report number 1036231149 of 06/12/23.

Certified Food Protection Manager: Penny J. Flitsch

Certification Number: FM4705 Expires: 02/05/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Penny Flitsch
Kitchen Manager

Signed: _____
Jeff Johanson