Electronically Delivered

December 27, 2023

Licensee
2 Caring Hands Inc
7166 205th Street West
Lakeville, MN 55044

RE: Project Number(s) SL27193015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 29, 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.

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

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 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.

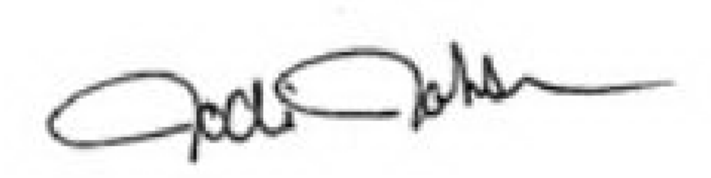
To submit a reconsideration request, please visit:

https://forms.web.health.state.mn.us/form/HRD-Appeals-Form

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

If you have any questions, please contact me.

Sincerely,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27193	A. BUILDING: _____ B. WING _____	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
2 CARING HANDS INC	7166 205TH STREET WEST LAKEVILLE, MN 55044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL27193015 On November 27, 2023, through November 29, 2023, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two active residents; two receiving services under the Assisted Living 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. 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). The findings include: On November 22, 2023, at 11:00 a.m. the Board of Executives for Long-Term Services and Support (BELTSS) website was reviewed. The website did not list LALD-A as the Director of Record for the licensee but was director of record for three other facilities. On November 27, 2023, at 9:30 a.m. during the entrance conference, LALD-A stated she had completed training and was the primary LALD for the licensee. On November 28, 2023, at 9:00 a.m. LALD-A stated she was not listed as director of record for this location on the BELTSS site. LALD-A further	0 110		

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0 110	Continued From page 2 stated she was the LALD for seven different sites. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes	0 250		

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0 250	Continued From page 3 access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to demonstrate they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. 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	0 250		

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0 250	Continued From page 4 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 November 27, 2023, at 9:30 a.m. during the entrance conference, licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: * I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. * I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. * Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. * Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. * Reporting of Maltreatment of Vulnerable Adults.	0 250		

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0 250	Continued From page 5 * Electronic Monitoring in Certain Facilities * I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. * I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. * I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 6 * I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. * I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by LALD-A on December 9, 2022. The licensee had an assisted living license reissued on March 1, 2023, with an expiration date of February 29, 2024. The licensee failed to ensure the following policies and procedures were developed and/or implemented for an assisted living facility : - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - orientation to and implementation of the assisted bill of rights; and - medication and treatment management As a result of this survey, the following orders were issued: 0450, 1290, 1470, 1830, 1870, 1880, 1890, 1910, 1940, 1950, 1960 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95.	0 250		

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0 250	Continued From page 7 No further information was provided.	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a Uniform Disclosure of Assisted Living Service and Amenities (UDALSA) as required. This had the potential to affect all residents living in the facility. 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	0 430		

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0 430	Continued From page 8 or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 started receiving services from the licensee on September 20, 2022, with a diagnosis that consisted of diabetes, personality disorder, obesity, and anxiety. On November 27, 2023, at 2:14 p.m. licensed assisted living director (LALD)-A stated the licensee had not completed a UDALSA for any residents. LALD-A stated she was unaware of the requirement and was still using comprehensive homecare services form. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;	0 450		

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0 450	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights for assisted living to one of one resident (R2). 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). The findings include: R2 started receiving services from the licensee on September 20, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2's diagnosis included diabetes, personality disorder, obesity, and anxiety. R2's record contained a copy of the signed homecare bill of rights on September 20, 2022; however, it failed to include a signed copy of the assisted living bill of rights. On November 27, 2023, at 2:14 p.m. licensed assisted living director (LALD)-A stated the files did not contain an assisted living bill of rights. The licensee's undated, Resident Record policy indicated the record would include documentation that the resident had received and reviewed the assisted living bill of rights.	0 450		

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0 450	Continued From page 10 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 28, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 11 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living. This had the potential to affect all residents receiving assisted living services. 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).	0 580		

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0 580	Continued From page 12 The findings include: During the entrance conference on November 27, 2023, at 9:30 a.m. the surveyor asked to review the quality meeting minutes. Licensed assisted living director (LALD)-A stated they have not completed any quality management activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
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 ensure the provider established and maintained a tuberculosis (TB) prevention	0 660		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 660	Continued From page 13 program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a facility risk assessment. 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 November 27, 2023, at 12:00 p.m. licensed assisted living director (LALD)-A and registered nurse (RN)-B indicated they had the TB risk assessment and would send it to the surveyor. On November 27, 2023, at 1:20 p.m. the surveyor received the TB risk assessment completed November 27, 2023 (survey date). The licensees undated, Tuberculosis Prevention and Control policy indicated the facility will complete the community TB risk assessments annually. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated July 2013, and based on CDC guidelines, indicated a TB risk assessment should be completed initially and then for low-risk settings the risk assessment should be updated every other year; each agency should have written TB infection control procedures.	0 660		

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0 660	Continued From page 14 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; (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 develop an all-hazards risk assessment emergency preparedness program	0 680		

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0 680	Continued From page 15 and plan to include Appendix Z required elements. 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 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 the residents). The findings include: During the entrance conference on November 27, 2023, at 9:30 a.m. the surveyor requested to view the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's plan lacked an all-hazards vulnerability assessment in addition to the following required content: - Maintain and Annual emergency preparedness (EP) updates - Process for EP collaboration - Subsistence needs for staff and patients - Procedure for tracking staff and patients - policies and procedures including evacuation - policies and procedures for sheltering - policies and procedures for medical documents - policies and procedures for volunteers - arrangement with other facilities - roles under a waiver declared by secretary - emergency officials contact information - primary/alternate means of communication - methods of sharing information - sharing information on occupancy/needs	0 680		

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0 680	Continued From page 16 - LTC family notifications - Emergency prep testing requirements On November 28, 2023, at 9:45 a.m. licensed assisted living director (LALD)-A stated they have not participated in a community wide drill, and everything they have completed was in their EP manual. The licensee's undated, Emergency Management policy referenced 144A Homecare statutes and failed to indicate an all-hazards risk assessment should be completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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 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	0 790		

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0 790	Continued From page 17 failed to provide current tags and documentation of annual and monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on November 30, 2023, at approximately 9:30 a.m., with Licensed Assisted Living Director (LALD-A), survey staff observed that the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that annual and monthly inspections had been performed as required. Annual and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. LALD-A verbally confirmed survey staff observations. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 18 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and	0 810		

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0 810	Continued From page 19 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 1, 2023, at 9:45 a.m., Licensed Assisted Living Director (LALD-A) provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated the evacuation plan did not include complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During interview on December 1, 2023, at 9:45 a.m., LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 20 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the assisted living license for one of one employee (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, 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: ULP-D was hired on April 10, 2020, to provide direct care services for the facility. On November 28, 2023, at 10:00 a.m. the	01290		

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01290	Continued From page 21 surveyor observed ULP-D provide direct assistance with activities of daily living (ADLs) to R2. ULP-D's employee record contained a background study affiliated with other licenses owned by the same licensee, dated September 26, 2020. ULP-D's record lacked evidence of the licensee affiliated a background study for this license. On November 28, 2023, at 1:35 p.m. licensed assisted living director (LALD)-A stated ULP-D's background study was not affiliated with this license. LALD-A further stated she was not aware staff had to be affiliated with each Health Facility Identification (HFID) number. The licensee's undated, Background Studies policy referenced 144A homecare statutes instead of assisted living statutes. The policy indicated employees may not work until the results of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff	01470		

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01470	Continued From page 22 person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated	01470		

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01470	Continued From page 23 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations for one of one employee (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, 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 the potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on April 10, 2020, to provide direct care services for the facility. On November 28, 2023, at 10:00 a.m. the surveyor observed ULP-D provide direct assistance with activities of daily living (ADLs) to R2. ULP-D's employee records lacked proof of receiving the following required orientation	01470		

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01470	Continued From page 24 content: - an overview of the assisted living statutes - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights. - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and - type of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure. On November 29, 2023, at 9:20 a.m. registered nurse (RN)-C stated ULP-D's record was missing required orientation and all staff files would be missing the same content. The licensee's undated, Qualifications, Training, and Competency policy indicated the facility shall implement and provide competency evaluation program that meets the minimum standards in accordance with state guidelines. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced	01830		

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01830	Continued From page 25 by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2's started receiving services from the licensee on September 20, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2 diagnosis included diabetes, personality disorder, obesity, and anxiety. R2's November medication record (MAR) indicated R2 was taking metoprol (for high blood pressure), refresh opthalmic dropps (for eye irritation), Spiriva (for asthma), and Victoza (for diabetes). R2's service plan dated September 20, 2022, indicated the resident received medication management services daily. R2's record had signed medication orders dated September 20, 2022. R2's record lacked evidence of current signed phyisician orders within the last 12 months of the last review date.	01830		

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01830	Continued From page 26 On November 27, 2023, at 11:35 a.m. registered nurse (RN)-B stated they do not keep physician orders in the file and was not aware that was a requirement. The licensee's undated, Medication Management Services policy indicated the facility will require a prescription for all medications that the facility will manage for all residents. The policy did not indicate prescriptions should be renewed every 12 months as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident's (R2) self-administered medications were included in the medication assessment for safety. 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	01870		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01870	Continued From page 27 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 started receiving services from the licensee on September 20, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2 diagnosis included diabetes, personality disorder, obesity, and anxiety. R2's Service Plan dated September 20, 2022, indicated R2 required assistance with bathing, medication administration, treatments, positioning, and transfers. The service plan indicated that all medications were kept in a locked central storage. On November 28, 2023, at 10:00 a.m., the surveyor observed following medications in R2's room: - one bottle of acetaminophen (pain reliever) - refresh ophthalmic solution (rewetting eye drops) R2's medication assessment dated September 20, 2022, indicated R2 required assistance with self-administration of medication. On November 28, 2023, at 10:20 a.m. licensed assisted living director (LALD)-A stated she was aware R2 kept medications in her room and that it was hard to control what she purchases and stores in her room.	01870		

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	27193	A. BUILDING: _____ B. WING _____	11/29/2023

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01870	Continued From page 28 The licensee's undated, Nursing Assessment and Reassessment of Residents policy indicated the registered nurse (RN) would complete a medication assessment to review all medications, indication of use, potential side effects and contraindications, adverse reactions, and interventions to prevent diversion of the medications by the residents or by others who have access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		
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 ensure all medications were securely locked in substantially constructed compartments and permit only authorized personnel had access. This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	01880		

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01880	Continued From page 29 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 November 27, 2023, at 9:30 a.m. during the entrance conference, licensed assisted living director (LALD)-A and registered nurse (RN)-B indicated the licensee provided medication management to all residents, and medications were securely stored in a locked cupboard or medication refrigerator located in the laundry room. The surveyor along with RN-B reviewed the medication refrigerator that did not contain a lock or a thermometer. The refrigerator contained R2's unopened insulin pens. - Humulog (Lispro) -Victoza On November 27, 2023, at 9:45 a.m. LALD-A stated the refrigerator was not locked and was not being monitored for temperatures. LALD-A stated she knew it was required and was not sure why this facility did not have it. The manufacturer's instructions for Victoza insulin pens dated September 2022, under section storing Victoza, indicated unused Victoza pen should be stored in the refrigerator at 36 degrees to 46 degrees. The manufacturer's instructions for Humalog (insulin lispro injection) dated March 2013, under section 16.2, storage, and handling, indicated unopened Humalog should be stored in a refrigerator at 36 degrees to 46 degrees.	01880		

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01880	Continued From page 30 The licensee's undated, Medication Management Services policy indicated the RN will develop and update as needed specific procedures including the controlling and storing medications. 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 maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of one resident (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:	01890		

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01890	Continued From page 31 On November 27, 2023, at 9:30 a.m. during the entrance conference, licensed assisted living director (LALD)-A and registered nurse (RN)-B indicated the licensee provided medication management to all residents, and medications were securely stored in a locked cupboard or medication refrigerator located in the laundry room. During the facility tour, RN-B reviewed the locked medication cupboard. The surveyor observed R2's Victoza insulin pen and Lispro (insulin) injection pen were not labeled with a discard date. RN-B stated the insulin pens did not have a discard date and was not aware that was a requirement. The manufacturer's instructions for Victoza insulin pens dated September 2022, directed to discard the pen 30 days after it had been opened. The manufacturer's instructions for Humalog (insulin lispro injection) dated March 2013, directed to discard a prefilled pen after 28 days, even if there is insulin left in the cartridge or pen. The licensee's undated, Medication Management Services policy indicated the RN will develop and update as needed specific procedures including the controlling and storing medications. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer	01910		

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01910	Continued From page 32 part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon discharge, to document in the resident's record the disposition of the medication including the medication's prescription number, as applicable, and to whom the medications were given for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on October 20,	01910		

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01910	Continued From page 33 2022, with a diagnosis of sepsis, obesity, and breast cancer and expired on July 10, 2023. R1's record lacked documentation of medication disposition upon the resident's discharge from the facility. On November 27, 2023, at 11:20 a.m. registered nurse (RN)-B indicated he was aware of the process for managing medications upon discharge, and stated R1 did not have a medication disposition form because he has not completed it yet. The medications were still in his home office. The licensee's undated, Medication Disposition or Disposal policy indicated that prescription drugs managed by the facility must be destroyed by the RN/LPN or pharmacist. Discontinued or unused drugs will be destroyed within one month or less of the time they are discontinued or the day or discharge or death. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	01940		

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01940	Continued From page 34 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2) who had treatments managed by the 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 of the residents).	01940		

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01940	Continued From page 35 The findings include: During the entrance conference on November 27, 2023, at 9:30 a.m. registered nurse (RN)-B stated the licensee provided treatment and therapy services to residents as prescribed. R2 started receiving services from the licensee on September 20, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2 diagnosis included diabetes, hypertension, personality disorder, obesity, and anxiety. On November 28, 2023, at 10:00 a.m. the surveyor observed unlicensed personnel (ULP)-D and licensed assisted living director (LALD)-A assisting R2 with morning cares, morning medications, blood sugar check and blood pressure check. R2's Service Plan dated September 20, 2022, indicated R2 required assistance with bathing, medication administration, treatments, positioning, and transfers. R2's prescriber orders dated May 3, 2023, included an order for blood sugar checks four times a day for diabetes. R2's record lacked a treatment plan. On November 28, 2023, at 11:35 a.m. RN-B stated they do not do a treatment plan at admission or annually and was not aware that was a requirement. The licensee's undated, Treatment and Therapy	01940		

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01940	Continued From page 36 Management policy indicated an individualized treatment plan for each resident receiving treatment or therapy services will be developed under the supervision and direction of a registered nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies 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 licensee failed to ensure instructions, specified in writing, for each resident and	01950		

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01950	Continued From page 37 documented those instructions in the resident's record for one of one resident (R2) who received blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's started receiving services from the licensee on September 20, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2 diagnosis included diabetes, hypertension, personality disorder, obesity, and anxiety. On November 28, 2023, at 10:00 a.m. the surveyor observed unlicensed personnel (ULP)-D and licensed assisted living director (LALD)-A assisting R2 with morning cares, morning medications, blood sugar check and blood pressure check. R2's prescriber orders dated May 3, 2023, included an order for blood sugar checks four times a day for diabetes. R2's Medication Administration Record (MAR) dated November 2023, directed for blood glucose checks to be completed four times a day (before each meal and at bedtime).	01950		

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01950	Continued From page 38 R2's record lacked specific written instructions to include parameters for evaluation of results and when to notify a nurse. On November 28, 2023, at 11:35 a.m. registered nurse (RN)-B stated R2's record did not contain parameters for when the ULP should notify the nurse for blood sugar checks. The licensee's undated, Treatment and Therapy Management policy indicated when administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility will ensure that the registered nurse has specified in writing detailed instructions for each resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01960		

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01960	Continued From page 39 review, the licensee failed to ensure treatment or therapies were administered as directed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's started receiving services from the licensee on September 20, 2022, to assist with activities of daily living (ADLs), medication administration, laundry, and housekeeping. R2 diagnosis included diabetes, high blood pressure, personality disorder, obesity, and anxiety. On November 28, 2023, at 10:00 a.m. the surveyor observed licensed assisted living director (LALD)-A administer morning medications to R2. The surveyor also observed LALD-A take R2's blood pressure and pulse fifteen minutes after the medication had been taken. R2's Medication Administration Record (MAR) dated November 2023, included an order dated September 20, 2022, to complete a daily blood pressure and pulse prior to morning medications and to notify the registered nurse (RN) for a blood pressure less than 90/60.	01960		

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01960	Continued From page 40 On November 28, 2023, at 11:35 a.m. LALD-A stated she should have taken blood pressure and pulse prior to giving morning medications. RN-B confirmed it was the expectation for all staff to follow the MAR. The licensee's undated, Treatment and Therapy Management policy indicated treatments and therapies shall be administered by facility staff only as ordered by the physician or designated prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

Minnesota Department of Health

625 Robert St N
St. Paul
55155

Type: Full
Date: *11/28/23*
Time: 10:15:00
Report: 1043231118

Food and Beverage Establishment Inspection Report

Location:
2 Caring Hands Inc. Spyglass M
7166 205th Street West
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0034363
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
2 Caring Hands Inc.

Phone #: 9522360672
ID #: 49338

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

The following orders were issued during this inspection.

3-300B 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.

RAW SHELL EGGS WERE STORED ON THE TOP SHELF IN THE COOLER ABOVE READY-TO-EAT FOODS (VEGETABLES AND BREAD). INSTRUCTED STAFF TO RELOCATE EGGS TO BOTTOM OF COOLER OR TO STORE WITHIN A BULK SIZE CONTAINER. COMPLY WITH ABOVE RULE.

Comply By: 11/28/23

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.

DISH MACHINE THERMOMETER WAS WORKING IMPROPERLY DURING INSPECTION. ADVISED STAFF TO MONITOR THERMOMETER OR REPLACE IT OR TO PROVIDE DISPOSABLE TEMPERATURE STRIPS/LABELS TO ENSURE TEMPERATURE IS REACHING AT LEAST 160F. COMPLY WITH ABOVE RULE.

Comply By: 11/28/23

5-200C Plumbing: Maintenance, fixture location

5-204.11 ***** Priority 2 *****

MN Rule 4626.1095 Locate a handwashing sink to allow convenient use in food preparation, food dispensing, warewashing areas and in or adjacent to toilet rooms.

KITCHEN HAS A TWO BASIN SINK. INSTRUCTED STAFF TO DESIGNATE ONE BASIN AS THE

HANDWASHING SINK AND PROVIDE A SIGN TO LABEL IT. COMPLY WITH ABOVE RULE.
Comply By: 11/28/23

3-500A Microbial Control: cooling

3-501.13ABC

MN Rule 4626.0380ABC Thaw TCS food by one of the following methods: 1. under mechanical refrigeration that maintains the food temperature at 41 degrees F (4 degrees C) or less; 2. completely submerged under running water at 70 degrees F (21 degrees C) or less with a velocity to remove loose particles on an overflow and the food is maintained at 41 degrees F (5 degrees C) or less; 3. in a microwave oven or; 4. as part of the cooking process.

FROZEN KEY LIME PIE WAS THAWED AT ROOM TEMPERATURE. STAFF RELOCATED FOOD TO COOLER. CORRECTED ON SITE. COMPLY WITH ABOVE RULE.
Comply By: 11/28/23

Food and Equipment Temperatures

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Process/Item: BUTTER
Temperature: 41 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

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

Discussed illness policy, sanitizer use, ware washing, temperature control, hand washing, cleaning, vomit/fecal procedures, test kits, highly susceptible populations, food storage, and food handling

Inspection was completed with N. Nowrang. Tracey Fearon was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

Facility currently has two residents with a maximum of four.
Food must be prepared for same day service only with leftovers discarded.

**This facility has a residential kitchen with residential equipment and wooden cabinetry. The kitchen finishes and surfaces are well maintained. The kitchen has wood laminate flooring, no base cove, and popcorn ceiling. Staff was advised to contact Health Regulation Division for plan review when facility undergoes remodeling.

**Unable to verify utensil surface temperature for the dish machine. Prior to inspection, the person in charge ran the dish machine with an irreversible thermometer but the temperature result was inconclusive. Inspector's thermolabel was used to run another cycle (~2 hour cycle) and requested person in charge to send results via email, no response.

Type: Full
Date: *11/28/23*
Time: 10:15:00
Report: 1043231118
2 Caring Hands Inc. Spyglass M

Food and Beverage Establishment Inspection Report

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 1043231118 of 11/28/23.

Certified Food Protection Manager: Gabriella A. Nowrang

Certification Number: FM111879 Expires: 06/22/25

Inspection report reviewed with person in charge and emailed.

Signed:_____
Nicholas S. Nowrang
PIC

Signed:_____
Blia Lor
Public Health Sanitarian I
OLF
651-231-7981
blia.lor@state.mn.us