Electronically Delivered

August 30, 2024

Licensee
James Residences
9400 James Avenue North
Brooklyn Park, MN 55444

RE: Project Number(s) SL32622015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 1, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

§ 144G.20.

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:

https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

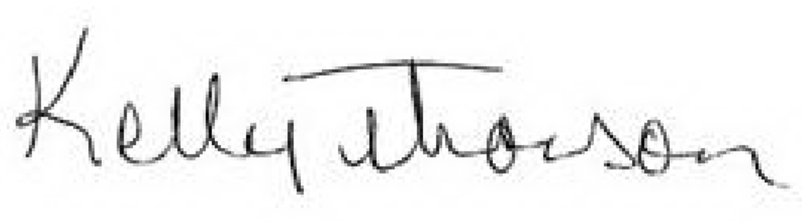
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	32622	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RESIDENCES	9400 JAMES AVENUE NORTH BROOKLYN PARK, MN 55444

(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: SL32622015 On July 29, 2024, through, August 1, 2024, 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 four resident(s); four receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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	0 470		

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of four residents and had a current census of four residents. On July 30, 2024, at 8:30 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the staffing plan is still in the works and is not yet completed. The licensee's Staffing policy dated August 1, 2021, indicated the clinical nurse supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet resident's needs at all times, including reasonably foreseeable needs. The staffing plan is based on an evaluation of the appropriateness of the staffing levels in the facility and is reviewed at least twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
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,	0 480		

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0 480	Continued From page 3 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 July 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	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 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.	0 510		

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0 510	Continued From page 4 (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On July 29, 2024, at 9:50 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R3. ULP-B opened the medication cabinet and removed a punch pack of medications without washing hands or looking at a medication administration record. ULP-B gave the medication to R2 who took them without issue. No hand hygiene was performed. On July 29, 2024, at 10:00 a.m., ULP-B stated we were trained to wash our hands in the morning, and I do not wash my hands in between each med pass. On July 30, 2024, at 8:50 a.m., licensed assisted	0 510		

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0 510	Continued From page 5 living director/clinical nurse supervisor (LALD/CNS)-A stated the expectation for staff performing medication administration is to wash hands. They have all been trained and competency tested to do this. The Center of Disease Control (CDC) Core Infection Prevention and Control Practices regarding hand hygiene dated November 29, 2022, recommends healthcare personnel should use an alcohol-based rub or wash with soap and water for the following clinical indications: immediately before touching a patient, before performing aseptic task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids, or contaminated services, and immediately after glove removal. The licensee's CDC Standard Precautions policy dated August 1, 2021, indicated hands should be washed at the following times: before assisting with medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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	0 680		

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0 680	Continued From page 6 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 have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, 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 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:	0 680		

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0 680	Continued From page 7 The licensee's undated EPP lacked documentation including all the required elements of: - annual reviews/updates of plan - missing resident quarterly review - annual review/update on policies and procedures -subsistence needs for staff and patients -procedures for tracking of staff and patients -policies and procedures for medical documents - policies and procedures for volunteers - roles under a waiver declared by secretary -names and contact information - methods for sharing information -sharing information on occupancy/needs On July 30, 2024, at 2:42 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the emergency plan has not been completed per requirements. They do discuss emergencies at each monthly meeting. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated [the Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 8 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all	0 810		

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0 810	Continued From page 9 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 31, 2024, at approximately 1:10 p.m. to 2:30 p.m., owner/licensed assisted living director/ clinical nurse supervisor (O/LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency. Emergency evacuation map did not show location and number of resident rooms. Emergency evacuation map had an emergency exit leading	0 810		

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0 810	Continued From page 10 out into the garage. The means of egress is required to lead and exit directly to a yard or court from occupied spaces within the facility or through a room of equal or less hazard which excludes the garage. TRAINING: The licensee failed to provide evacuation training to staff and residents as required. O/LALD/CNS-A lacked documentation showing that any training was offered. On July 31, 2024, at 2:15 p.m., O/LALD/CNS-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in	01620		

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(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 11 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) used the uniform assessment tool for ongoing assessments and monitoring for one of one 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 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: R1 was admitted and began receiving services on February 1, 2024. R1's record included an initial comprehensive assessment dated February 1, 2024, a 14-day assessment dated February 14, 2024, and a 90-day assessment dated May 14, 2024. R1's 14-day and 90-day assessments did not include the following required elements on the uniform assessment tool: -the resident's personal lifestyle preferences,	01620		

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	32622	A. BUILDING: _____ B. WING _____	08/01/2024

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01620	Continued From page 12 including sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life, spiritual and cultural preferences, and advance health care directives and end-of-life preferences - activities of daily living, including toileting pattern, dressing, grooming, bathing, and personal hygiene, mobility, including ambulation, transfers, and assistive devices and eating, dental status, oral care, and assistive devices and dentures. - instrumental activities of daily living, including housework and laundry and transportation - physical health status, including a review of relevant health history and current health conditions including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities and life threatening, infectious conditions, a review of medications, a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months, weight, and initial vital signs if indicated by health conditions or medications - emotional and mental health conditions, including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, effective medication treatment and non-medication interventions - cognition, including a review of any neurocognitive evaluations and diagnoses - communication and sensory capabilities, including speech, assistive communication and	01620		

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01620	Continued From page 13 sensory devices including hearing aids, and the ability to understand and be understood -nutritional and hydration status and preferences - list of treatments, including type, frequency, and level of assistance needed - nursing needs, including potential to receive nursing-delegated services - risk indicators including risk for falls including history of falls, emergency evaluation ability, complex medication regimen, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk including history or previous elopements, smoking, including the ability to smoke without causing burns or injury to the resident or others or damage property and alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician - who has decision making authority for the resident including the presence of any advance health care directive or other legal document that establishes a substitute decision maker and the scope of decision-making authority of a substitute decision maker under subitem (1) - the need for follow-up referrals for additional medical or cognitive care by health professionals On July 30, 2024, at 2:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was using the forms they had gotten from their consultant company and was aware she should have been using a uniform assessment tool. They have been using the same form for all resident assessments. The Minnesota Administrative Rule 4659.0150 dated August 11, 1021, indicated each facility	01620		

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01620	Continued From page 14 must develop a uniform assessment tool to include all the required elements. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the registered nurse (RN) will conduct a comprehensive assessment for all residents admitted to [the facility] to determine services required and to develop an individualized care plan for staff to implement. The assessment addressed the resident's physical, mental, and cognitive needs. The RN will conduct a comprehensive assessment utilizing a uniform assessment tool. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain current medication orders for one of one 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, but was not likely to cause serious injury, impairment, or death), and	01820		

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01820	Continued From page 15 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's service plan, dated February 1, 2024, indicated R1 received medication administration services. R1 had diagnoses including end stage kidney disease, anemia, hyperkalemia, and depression. R1's medication administration record (MAR) dated July 2024, included the following scheduled medications: -amlodipine besylate 10 mg tab, take one tablet by mouth once a day for blood pressure -aripiprazole 15 mg tablet, take one tablet by mouth daily at bedtime an antipsychotic -bupropion HCL XL 150 mg tablet, take one tablet by mouth once a day an antidepressant -buspirone HCL 10 mg tablet, take one tablet by mouth twice a day for anxiety -carvedilol 25 mg tablet, take one tablet by mouth twice a day for blood pressure -cinacalcet HCL 90 mg tablet, take one tablet by mouth once a day for kidney disease -gabapentin 100 mg capsule, take two capsules by mouth twice a day for seizures -lanthanum carb 500 mg tab chew, chew two tablets by mouth three times daily with meals or snacks for kidnsy disease -Lokelma 5-gram powder packet, take one packet by mouth on non-dialysis days for high potassium -mycophenolate 250 mg capsule, take 2 capsules by mouth twice a day anti rejection -prednisone 5 mg tablet, take one tablet by mouth once a day a steroid	01820		

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01820	Continued From page 16 -sertraline HCL 50 mg tablet, take one tablet by mouth once a day for depression -sodium bicarb 650 mg tablet, take one tablet by mouth twice a day antacid -vitamin D3 1,000-unit tab chew, take one tablet by mouth once a day supplement -adapalene 0.1% cream, apply a thin layer to the face once a day for acne -Drysol solution 20%, apply solution between the toes and to soles of feet three times a week at night for sweating On July 30, 2024, at 1:40 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they do not have signed provider orders for R1. They only have after visit summaries and discharge orders. LALD/CNS-A further stated it is very hard to get signed orders without making an appointment. The licensee's Medication Orders policy dated August 1, 2021, indicated [the facility] will maintain a current written or electronically recorded prescription for all prescribed medications for the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01820		
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	01890		

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01890	Continued From page 17 drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor for expired medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On July 29, 2024, at 1:15 p.m., the surveyor observed the medication cabinet. The surveyor found the following expired medication punch packs: -ibuprofen- discard after June 15, 2024 -tizanidine 2 mg- expired March 3, 2024 On July 30, 2024, at 3:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she usually checks for expired medications but missed a couple. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated medications for a resident who is deceased or that have been discontinued or expired may be provided for disposal. No further information was provided.	01890		

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01890	Continued From page 18 TIME PERIOD FOR CORRECTION: seven (7) days	01890		
02320 SS=F	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of one employee (unlicensed personnel/ULP-B). 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: ULP-B had a hire date of November 14, 2021. ULP-B's employee record contained documentation that ULP-B had completed a medication administration competency evaluation with licensed assisted living director/clinical nurse	02320		

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02320	Continued From page 19 supervisor (LALD/CNS)-A upon hire. On July 29, 2024, at 9:50 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R3. ULP-B opened the medication cabinet and removed a punch pack of medications without looking at a medication administration record. ULP-B gave the medication to R2 who took them without issue. On July 29, 2024, at 10:00 a.m., ULP-B stated sometimes I look at a MAR but since I am familiar with the residents and their meds, I don't always look at the MAR. I was trained to look at the MAR every morning. On July 30, 2024, at 8:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the expectation for staff performing medication administration is to check the MAR, get the medications out of the cabinet, compare the punch pack with the MAR using the 5 rights of medication administration, offer fluids, observe the resident swallow their medications, and document. They have all been trained and competency tested to do this. The licensee's Supervision: Unlicensed Staff policy dated August 1, 2021, indicated supervision of home health aides performing medication or treatment administration shall be provided by the RN and include observation of the staff administering the medication or treatment and interacting with the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *07/29/24*
Time: 12:30:28
Report: 1050241131

Food and Beverage Establishment Inspection Report

Location:
James Residences
9400 James Avenue North
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0039189
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632229503
ID #:

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

The following orders were issued during this inspection.

3-700 Contaminated Food: discarded

3-701.11A ***** Priority 1 *****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

OBSERVED MILK INSIDE REACH IN COOLER WITH A TEMPERATURE OF 55F. DISCUSSED ALL CHILLED ITEMS MUST BE 41F AND BELOW. STAFF DISCARDED MILK. COOLER WAS NOT SET TO RECOMMENDED TEMPERATURE FIXED ON SITE. COMPLY WITH RULE ABOVE.

Comply By: 07/30/24

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

FACILITY DOES NOT HAVE A THIN PROBE THERMOMETER. COMPLY WITH RULE ABOVE.

Comply By: 07/30/24

2-100 Supervision

2-102.12AMN

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

FACILITY DOES NOT HAVE A CURRENT MN CFPM CERTIFICATION ON SITE. DISCUSSED REQUIREMENTS AND MDH FACT SHEETS PROVIDED VIA EMAIL. COMPLY WITH RULE ABOVE.

Comply By: 09/02/24

Type: Full
Date: *07/29/24*
Time: 12:30:28
Report: 1050241131
James Residences

Food and Beverage Establishment Inspection Report

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

Announced inspection completed 7/29/24 with MDH Andrew Spaulding and staff member Haja Saukoh. Wendy Robarge was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection. Meals are prepared on site and shopping is completed by staff.

This establishment has a residential kitchen. Food is prepared for same day service if leftovers kept no longer than 2 days. The kitchen has wood cabinets with a hollow base and wooden flooring, popcorn ceiling. All found to be in good condition. Work order for leak under sink was completed the wood needs to be replaced.

Discussed the following:
-Employee illness policy and logging requirements
-Hand Washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

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 1050241131 of 07/29/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Copy of inspection report reviewed with person in charge and mailed certified.

Signed:_____
NATALIE CAMPBELL
OWNER

Signed:_____
Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us