Electronically Delivered

March 28, 2025

Licensee
Personal Care Management LLC
525 Cutter Street
Anoka, MN 55303

RE: Project Number(s) SL36849016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 28, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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 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

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
	36849	A. BUILDING: _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36849016-0 On February 24, 2025, through February 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 19 residents; 19 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (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 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	0 470		

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 32 residents and had a current census of 19 residents. On February 26, 2025, at 9:10 a.m., licensed assisted living director (LALD)-A stated they did not have documentation a staffing plan that had been evaluated and reviewed twice a year because they do this on almost a daily basis and will add more staff based on the number of residents and the acuity of their care. The licensee's Staffing, Direct-Care Staffing Plan and Daily Schedule policy dated January 23, 2025, indicated a clinical nurse supervisor, or designee, will develop, write, and implement a staffing plan. The staffing plan will be evaluated for the appropriately of staffing levels in the facility and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 4 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 24, 2025, 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 5 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 facility. This had the potential to affect the licensee's current resident. 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).	0 580		

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0 580	Continued From page 6 The findings include: On February 26, 2025, at 9:10 a.m., licensed assisted living director (LALD)-A stated they do not have documented evidence of quality assurance meetings, but management has discussions about this almost daily, but it is not documented anywhere. The licensee's Quality Management Plan policy dated July 10, 2023, indicated the LALD or designee will establish a quality management program to develop and maintain the agencies continuous performance improvement efforts. Minutes of the quality meetings will be summarized for all staff to review and these summaries will be available to staff upon request. Quality meeting minutes will be retained for two years and will be made available to the commissioner at the time of survey, investigation, or renewal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650		

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0 650	Continued From page 7 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included all required content (annual performance review) for one of three 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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: ULP-D was hired on October 11, 2023, to provide direct care services to residents. ULP-D's employee record lacked evidence an	0 650		

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0 650	Continued From page 8 annual performance review was completed. On February 26, 2025, at 8:15 a.m., clinical nurse supervisor (CNS)-B stated he owes ULP-D an annual performance review because it has not been completed yet, they were taking care of a coaching/reeducation issue first before the annual review was completed. The licensee's Performance Review policy dated July 11, 2023, indicated each supervisor will complete the annual performance review form for each employee they supervise prior to the employee's anniversary date. The supervisor will meet with employees annually on or before their anniversary date to review the employee's feedback, review the supervisor's assessment of the employee's performance, and discuss goals for the upcoming period. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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;	0 680		

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0 680	Continued From page 9 (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 a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, employees, and visitors to 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 the residents). The findings include: The licensee's undated EPP, lacked the required content: - development and maintenance of the EPP; - maintain annual updates; - a quarterly review of missing resident policy; - identify program patient population;	0 680		

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0 680	Continued From page 10 - a process for emergency preparedness (EP) collaboration with local, tribal, regional, State and Federal EP officials to maintain integrated response; - the development of policies/procedures to address: - subsistence needs for staff and patients; - procedures for tracking staff and residents; - procedure including evacuation; - procedure for medical documents; - use of volunteers; - arrangement with other facilities; and - roles under a waiver declared by the secretary. - a communication plan that included: - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, state licensing and certification agency, or the ombudsman for long term care; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to provide information about the facility's occupancy, needs, and it's ability to provide assistance to the authority having jurisdiction, the incident command center, or a designee; - LTC family communications; and - documentation EPP exercise has been tested twice a year. On February 26, 2025, at 9:10 a.m., licensed assisted living director (LALD)-A acknowleded the EPP was missing the annual review, quarterly review of the missing person policy, documented drills completed twice a year, and several of the other required components and stated they may be on a share drive on the computer, but have	0 680		

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0 680	Continued From page 11 not been added to the EPP binder. The licensee's undated, Plans for Natural Disasters and Emergencies policy indicated the licensee will have a written plan of action to facilitate our clients care and services in response to a natural disaster or another type of emergency that may affect our ability to provide services. This plan will be updated regularly and will be coordinated with local emergency responders, and where appropriate, with the management of senior housing buildings or HWS establishments where our clients live. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This deficient condition had	0 775		

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0 775	Continued From page 12 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 27, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: Controlled Egress Door Locking System - Electromagnetic locks were installed on the emergency exit doors, these doors required use of a frequency operated device to unlock. During an interview on February 27, 2025, at 12:30 p.m., LALD-A verified the above listed door locking observations. The entire egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the locks. Egress control locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511 for the entire locking system. - On February 27, 2025, LALD-A provided emergency plan procedures. Record review indicated the emergency plan did not include procedures to operate and unlock the electromagnetic controlled locking door system.	0 775		

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0 775	Continued From page 13 During an interview on February 27, 2025, at 12:30 p.m., LALD-A verified this information was not included in the plan. Fire Door Maintenance The door closer arm was disconnected on the labeled fire door for the whirlpool room on the assisted living side of the building. The fire door did not self-close and positively latch as designed. All components of a fire door assembly must be maintained in proper working order. During the tour interview, LALD-A verified the above listed fire door observation. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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 failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and	0 790		

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0 790	Continued From page 14 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 27, 2025, at 10:30 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: - Annual maintenance tags dated August 2021 were attached to the portable fire extinguishers installed in the assisted living laundry room, sprinkler riser room, dementia care electrical room, and dementia care laundry room. Annual maintenance performed by certified service personnel must be completed on all portable fire extinguishers installed in the facility. - Monthly inspections were not recorded on the back of the tags attached to the portable fire extinguishers installed in the assisted living nurse station, at the main entrance, and in the dementia care nurse station. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, that it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview on February 27, 2025, LALD-A verified the above listed fire	0 790		

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0 790	Continued From page 15 extinguisher observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 16 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content and provide required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 27, 2025, licensed assisted living director (LALD)-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 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 employee actions were limited to verifying the fire location, calling 911, verifying the safety of the residents, and meeting emergency response personnel. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP must be developed with procedures specific to the facility and the building occupants.	0 810		

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0 810	Continued From page 17 During an interview, on February 27, 2025, at 12:30 p.m., LALD-A verified the FSEP required revision. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of fire drill response forms lacking the required documentation. Six fire drills were recorded between February 2024 and February 2025. The time or shift of the drills were not recorded on the May, July, August, and October drill records. The names of the employees who had participated in the drills were not recorded on the response forms. During an interview, on February 27, 2025, at 12:30 p.m., LALD-A verified the time or shift had not been recorded on all of the drill forms. LALD-A stated the names of the employees who had participated in the fire drills were recorded on staff meeting records and not on the drill forms. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal	01370		

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01370	Continued From page 18 hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for one of three 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	01370		

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01370	Continued From page 19 cause serious injury, impairment, or death and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 25, 2025, at 11:00 a.m., the surveyor observed ULP-D administer medications to residents. ULP-D was hired on October 11, 2023, to provide direct care services to the residents. ULP-D's employee record lacked evidence of completed training and/or competency testing for the following: - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; and - dressing and assisting with toileting. On February 26, 2025, at 1:45 p.m., clinical nurse supervisor (CNS)-B stated he agrees some of the required topics for orientation are missing evidence the training and competency had been completed by the unlicensed staff. CNS-B stated this orientation was completed prior to his employment and must have been missed. The licensee's Assisted Living Orientation-ULP Staff policy dated January 23, 2025, indicated in addition to training all staff receive, ULP's who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: - appropriate and safe techniques in personal	01370		

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01370	Continued From page 20 hygiene and grooming. In addition to training and all staff receive, ULP's who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test AND a skill demonstration: -hair care and bathing; -care of teeth, gums, an oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	01380		

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01380	Continued From page 21 Based on observation, interview, and record review, the licensee failed to ensure training and/or competencies were completed and documented for one of three 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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On February 25, 2025, at 11:00 a.m., the surveyor observed ULP-D administer medications to residents. ULP-D was hired on October 11, 2023, to provide direct care services to residents. ULP-D's employee record lacked evidence of completed training and/or competency testing for the following: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On February 26, 2025, at 1:45 p.m., clinical nurse supervisor (CNS)-B stated he agrees some of the required topics for orientation are missing	01380		

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01380	Continued From page 22 evidence the training and competency had been completed by the unlicensed staff. CNS-B stated this orientation was completed prior to his employment and must have been missed. The licensee's Assisted Living Orientation-ULP Staff policy dated January 23, 2025, indicated in addition to training all staff receive, ULP's who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01420 SS=F	144G.62 Subd. 2 Delegation of assisted living services (b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If the unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel	01420		

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01420	Continued From page 23 must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted training and competency evaluations for one of one unlicensed personnel (ULP-D) who provided direct care to 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 to the licensee on September 15, 2022, with diagnoses including type 2 diabetes, congestive heart failure, hypertension, and peripheral vascular disease. R1's Service Plan dated September 15, 2022, indicated R1 received services to include medication administration, blood glucose monitoring, dressing, grooming, bathing, toileting, and transfer assist. R1's Services Delivered dated February 1, 2025, through February 24, 2025, indicated ULP-D provided catheter care services to R1 on February 6, 9, 14, and 15, 2025.	01420		

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01420	Continued From page 24 ULP-D's record lacked documentation to indicate ULP-D had received training and demonstrated competency for catheter care. On February 25, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-B stated ULP-D's record lacked training and competency for R1's catheter care and this probably should have been completed due to the staff being unlicensed. CNS-B stated he will need to compete the training and competency for all the staff on catheter care. The licensee's Delegation of Nursing Tasks policy dated July 11, 2023, indicated before delegating or assigning a task to unlicensed personnel, the RN or Licensed Health Professional must determine that each staff member who will perform the task is trained and competent to perform the task and has been instructed in the proper procedures for performing the procedures with respect to the specific client. The RN or Licensed Health Professional will assure that training and competency records for all unlicensed staff are kept up-to-date and are easily accessible. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01420		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living	01440		

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01440	Continued From page 25 facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an appropriate licensed health professional, or a registered nurse (RN) conducted direct supervision of staff performing a delegated task within thirty calendar days after the date on which the individual began working for the facility and first performed the delegated task for one of three 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	01440		

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01440	Continued From page 26 situation has occurred only occasionally). The findings include: On February 25, 2025, at 11:00 a.m., the surveyor observed ULP-D administer medications to residents. ULP-D was hired on October 11, 2023, to provide direct care services to residents. ULP-D's employee record lacked evidence a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services. On February 26, 2025, at 8:15 a.m., clinical nurse supervisor (CNS)-B stated he was unable to find a 30 day supervision in ULP-D's employee record and he thought it must have been missed, this was prior to his employment with the licensee. The licensee's Personnel Records policy dated July 11, 2023, indicated a personnel file will be maintained for each paid employee. The personnel record for each person will include: - results of supervision observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another	01500		

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	36849	A. BUILDING: _____ B. WING _____	02/28/2025

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01500	Continued From page 27 source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss	01500		

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01500	Continued From page 28 and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included at least eight hours of annual training for each 12 months of employment in the required topics for three of three employees (unlicensed personnel (ULP)-C, ULP-D, and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on August 8, 2022, to provide direct care services to residents. On February 25, 2025, at 10:00 a.m., the surveyor observed ULP-C administer R1's	01500		

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01500	Continued From page 29 medications. ULP-C's employee record lacked documentation of annual training to include: - infection control techniques. ULP-D was hired on October 11, 2023, to provide direct care services to residents. On February 25, 2025, at 11:00 a.m., the surveyor observed ULP-D administer medications to residents. ULP-E was hired on August 8, 2022, to provide direct care services to residents. On February 25, 2025, at 8:15 a.m., the surveyor observed ULP-E feeding residents. ULP-D and ULP-E's employee record lacked documentation of any annual training which included: - reporting maltreatment of vulnerable adults or minors; - Assisted Living Bill of Rights; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. On February 26, 2025, at 1:45 p.m., clinical nurse supervisor (CNS)-B stated he agrees the annual training seems to be an issue and he assumes the training classes were not assigned which is	01500		

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01500	Continued From page 30 why they are missing from the employee records. The licensee's Assisted Living with Memory Care Annual Training policy dated January 23, 2025, indicated all of our assisted living employees will complete annual education on the following topics: - reporting of maltreatment of vulnerable adults under section 626.557 - Assisted Living Bill of Rights - staff responsibility related to ensuring the exercise and protection in the assisted living Bill of Rights - infection control techniques used in the home and implementation of infection control standards; - effective approaches for problem solving when working with challenging behaviors; - effective approaches for communication with residents with dementia, Alzheimer's disease, or related disorders; - review of policies and procedures relating to the provision of assisted living services and how to implement them; - principles of person centered planning and service delivery; - how person centered planning and service delivery applies to direct support services provided by staff; and - emergency and disaster training. Direct care staff will complete 8 hours of annual training for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01530	Continued From page 31	01530		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all employees received eight (8) hours of initial dementia care training within the first 160 working hours of employment for one of three employees, (unlicensed personnel (ULP)-D; and two (2) hours of annual dementia care training for direct care employees as required for one of two employees,	01530		

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01530	Continued From page 32 (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: INITIAL DEMENTIA TRAINING ULP-D was hired on October 11, 2023, to provide direct care services to residents. On February 25, 2025, at 11:00 a.m., the surveyor observed ULP-D administer medications to residents. ULP-D's education transcript dated February 7, 2024, included the following dementia care training: - Dementia - Person-Centered Care (0.75 hours) completed October 12, 2023; -Dementia - Problem Solving - Anger and Aggression (.50 hours) completed October 12, 2023; - Dementia - Problem Solving - Anxiety (.50 hours) completed October 12, 2023; - Dementia - Problem Solving - Use of Medication (.75 hours) October 12, 2023; - Dementia 1 - Introduction and Overview (1.00 hour) completed October 18, 2023; - Dementia 2 - Communication (1.25 hours) completed October 18, 2023; - Dementia 3 - Activities of Daily Living (1.00 hour) completed October 18, 2023; and	01530		

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01530	Continued From page 33 -Dementia 5 - The Journey (.75 hours) completed October 18, 2023. ULP-D had six and a half (6.5) hours on initial dementia training completed. ANNUAL DEMENTIA TRAINING ULP-E was hired on August 8, 2022, to provide direct care services to residents. On February 25, 2025, at 8:15 a.m., the surveyor observed ULP-E feeding residents. ULP-E's employee record lacked any annual dementia care training. On February 26, 2025, at 1:45 p.m., clinical nurse supervisor (CNS)-B acknowledged ULP-D's employee record only showed six and a half (6.5) hours of initial dementia care training not the required eight (8) hours and ULP-E's employee record did not show any annual dementia care training. CNS-B stated he assumes the classes were missed being assigned to the staff and they would need to have these staff take this training. The licensee's Assisted Living with Memory Care Dementia Training policy dated January 23, 2025, indicated direct care employees will: - complete a minimum of eight hours of initial training on dementia care topics; and - initial training will be completed within 80 working hours of the employment start date. Direct-care employees will have a minimum of two hours training on topics related to dementia for each 12 months of employment. No further information provided.	01530		

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01530	Continued From page 34 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=D	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 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) completed a timely comprehensive assessment for a change in condition for one of one resident (R1)	01620		

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01620	Continued From page 35 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R1 was admitted to the licensee on September 15, 2022, with diagnoses including type 2 diabetes, congestive heart failure, hypertension, and peripheral vascular disease. R1's Service Plan dated September 15, 2022, indicated R1 received services to include medication administration, blood glucose monitoring, dressing, grooming, bathing, toileting and transfer assist. R1's resident notes included the following entries: - January 2, 2025, at 1:00p.m., clinical nurse supervisor (CNS)-B indicated that the wound care nurse recommended hospitalization for wound with possible osteomyelitis and R1 agreed to be evaluated. - January 15, 2025, at 8:26 a.m., CNS-B indicated R1 will discharge from the hospital to a transitional care unit (TCU) for further care. - February 6, 2025, at 5:22p.m., CNS-B indicated R1 returned to the facility from the TCU unit and was having some issues with the wound vacuum on his wound. R1's resident record lacked a change of condition	01620		

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01620	Continued From page 36 assessment completed upon the return from his hospitalization and TCU stay. On February 25, 2025, CNS-B stated he completed an assessment on R1 when he returned from the hospital/TCU stay, but had forgotten to document the assessment. The licensee's Initial and On-going Nursing Assessment of Residents policy dated July 11, 2023, indicated the RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required: - pre-admission assessment; - 14-day assessment: completed up to 14-days after start of services; - ongoing assessments: completed periodically but no less than every 90-days; and - change in resident condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident	01640		

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01640	Continued From page 37 about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a service plan within 14 days of admission for two of four residents (R2 and R5). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 was admitted to the licensee on June 17, 2024, with diagnoses including Lewy body dementia (progressive brain disorder), diabetes mellitus, Parkinson's Disease (progressive neurological disorder that affects movement, balance, and coordination).	01640		

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01640	Continued From page 38 R2's resident record lacked evidence of a signed service plan. On February 25, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-B stated he was unable to find a signed service plan for R2 and it must have been missed at admission. R5 admitted to the licensee on January 23, 2023, with diagnoses that included Alzheimer's disease (progressive neurodegenerative disorder that gradually destroys memory), generalized anxiety disorder, peripheral vascular disease, and chronic pain. R5's resident record lacked evidence of a signed service plan. On February 26, 2025, at 12:00 p.m., director of nursing (DON)-F stated they are unable to find a signed service plan for R5 in her record, it was completed at move in, but must have been misplaced. The licensee's Contents of Service Plans policy dated July 11, 2023, indicated a finalized service plan will be completed no later than 14 calendar days after initiation of services. Service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications	01880		

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01880	Continued From page 39 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 prescription medications were stored according to the manufacturer's guidelines for two of two residents (R1 and R4). 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 February 25, 2025, at 2:55 p.m., the surveyor observed the medication refrigerator with clinical nurse supervisor (CNS)-B which contained several medications for the residents of the facility. The refrigerator contained insulin glargine (Lantus) (long-acting insulin) which was prescribed to R1. It also included Lantus (long-acting insulin) and insulin lispro (Humalog) (short-acting insulin) which were prescribed to R4. The medication refrigerator temperature log dated January 1, 2025, through February 24, 2025 indicated the temperature was above 46 ° on January 2, 3, 5, 6, 9, 14, 17, 23, 25, 26, 27,	01880		

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01880	Continued From page 40 29, and 30, 2025 and February 2, 3, 4, 12, 13, 14, 16, 17, 18, 19, 20, 21, 22, 23, and 24, 2025. On February 26, 2025, at 8:15 a.m., CNS-B stated he agrees the temperature readings are outside of the 36 - 46 ° range and he thinks this is due to the placement of the thermometer, the frequent door opening, and the quality of the refrigerator. The manufacturer's guidelines for Lantus insulin pens dated, August 2022, recommended to store the insulin pen in the refrigerator between 36°F to 46°F. The manufacturer's guidelines for Humalog insulin pens dated August 2023, recommended store unused pens in the refrigerator at 36°F to 46°F. The licensee's Storage of Medications policy dated July 11, 2023, indicated when secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

(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
01950	Continued From page 41 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 interview and record review, the licensee failed to ensure training and competency was completed for blood glucose monitoring for one of one employee unlicensed personnel (ULP)-D) who provided direct care to 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 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 licensee on September 15, 2022, with diagnoses including type 2 diabetes, congestive heart failure, hypertension,	01950		

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01950	Continued From page 42 and peripheral vascular disease. R1's Service Plan dated September 15, 2022, indicated R1 received services to include medication administration, blood glucose monitoring, dressing, grooming, bathing, toileting, and transfer assist. R1's Services Delivered dated February 1, 2025, through February 24, 2025, indicated ULP-D provided blood glucose monitoring to R1 on February 11, and 13, 2025. ULP-D's record lacked documentation to indicate ULP-D had received training and demonstrated competency for blood glucose monitoring. On February 25, 2025, at 3:30 p.m., clinical nurse supervisor (CNS)-B stated ULP-D's record lacked training and competency for R1's blood glucose monitoring and he would need to complete this training and competency with ULP-D, it was missed. The licensee's Delegation of Nursing Tasks policy, dated July 11, 2023, indicated a registered nurse may delegate nursing services, or an authorized Licensed Health Professional may delegate treatments or assign therapy tasks, to unlicensed personnel that: - have successfully completed the training required for unlicensed personnel; - have been trained in the services to be provided; and - have demonstrated to the RN or the Licensed Health Professional the ability to competently follow the procedures for the client and possess the knowledge and skills consistent with the complexity of the tasks.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	02/28/2025

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01950	Continued From page 43 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors. This deficient practice had the ability to affect all dementia care residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	02040		

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	36849	A. BUILDING: _____ B. WING _____	02/28/2025

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02040	Continued From page 44 Findings include: On February 27, 2025, the surveyor requested a copy of the safety risk assessment or hazard vulnerability assessment of the physical environment with mitigation factors from licensed assisted living director (LALD)-A. The assessment was not provided. LALD-A stated if this assessment was located, it would be emailed to the surveyor by the end of the day. On February 27, 2025, at 1:30 p.m., LALD-A emailed a 2023 risk assessment tool to the surveyor. The completed assessment did not include physical environment risks with mitigation factors specific to protecting the dementia care residents from harm. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36849	A. BUILDING: _____ B. WING _____	02/28/2025

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PERSONAL CARE MANAGEMENT LLC	525 CUTTER STREET ANOKA, MN 55303

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02110	Continued From page 45 a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents with dementia care. 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	02110		

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02110	Continued From page 46 portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license through September 30, 2025, and was licensed for a bed capacity of 32 residents. On February 24, 2025, at 1:30 p.m., the surveyor asked to see the dementia care policies given to the residents at the time of move-in and received the policies. On February 25, 2025, at 2:30 p.m., licensed assisted living director (LALD)-A stated they have not given the residents or their power of attorney (POA) the 10 dementia care policies at time of move in. LALD-A stated when asked for them at start of the survey she had found them in the shared drive on the computer, but they do not have any evidence the policies were given at admission but will be adding this to the checklist they currently use. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *02/24/25*
Time: 13:00:46
Report: 1029251057

Food and Beverage Establishment Inspection Report

Location:

Personal Care Management Llc
525 Cutter Street
Anoka, MN55303
Anoka County, 02

Establishment Info:

ID #: 0037457
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7633359590
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 previously issued on 08/02/22 have NOT been corrected.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

8/2/22-2/24/25: BUTTER AND BUTTER PACKETS ON COUNTER W/OUT TPHC OR TAGGING MEASURED IN DANGER ZONE. REP INSTRUCTED TO DISCARD AT SET TIME AND TO DISCONTINUE W/OUT TPHC. TPHC INFO SENT WITH REPORT.

Issued on: 08/02/22 *Comply By: 08/02/22*

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

8/2/22-2/24/25: CFPM CERTIFICATE NOT POSTED. POST CFPM CERTIFICATE.

Issued on: 08/02/22 *Comply By: 08/02/22*

The following orders were issued during this inspection.

3-500C Microbial Control: date marking

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

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

OPEN BAG OF PREPACKAGED SALAD MIX W/OUT DATE MARK. REP INSTRUCTED TO DATE MARK REQUIRED ITEMS AND DISCARD IF NOT USED BY END OF 7TH DAY. LISTERIA DISCUSSED.

Comply By: 02/24/25

4-300 Equipment Numbers and Capacities

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

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

MIN/MAX THERMOMETER NOT WORKING. REP INSTRUCTED TO OBTAIN WORKING MIN/MAX THERMOMETER OR THERMAL STICKERS TO VERIFY SANITIZING TEMPS IN DISHWASHER.

Comply By: 02/24/25

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

SPRAY BOTTLE WITH DEGREASER W/OUT LABEL AND SPRAY BOTTLE WITH MYSTERY LIQUID W/OUT LABEL. REP INSTRUCTED TO ENSURE ALL CHEMICALS REMOVED FROM THEIR ORIGINAL CONTAINERS HAVE IDENTIFIERS WRITTEN ON THEM.

Comply By: 02/24/25

4-200 Equipment Design and Construction

4-204.11

MN Rule 4626.0565 Prevent grease or condensation from exhaust ventilation hood systems from draining or dripping onto food, equipment, utensils, linens, single-service articles, and single-use articles.

STAINLESS STEEL WALL BEHIND GRIDDLE AND OTHER EQUIPMENT WITH GREASE AND GRIME. CLEAN AND MAINTAIN CLEAN.

Comply By: 02/24/25

4-500 Equipment Maintenance and Operation

4-501.11AB

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

DISWASHER LEAKING AND POOLING WATER ON FLOOR. REPAIR OR REPLACE DISHWASHER SO THAT IT DOES NOT LEAK.

Comply By: 02/24/25

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

ACCUMULATION OF DUST AND DEBRIS ON CEILING AND VENT ABOVE SERVICE WINDOW AREA IN KITCHEN. CLEAN AND MAINTAIN CLEAN.

Comply By: 02/24/25

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.

CEILING PANEL MISSING OVER DRYING RACK AREA. PROVIDE CEILING THROUGHOUT KITCHEN AREA.

Comply By: 02/24/25

6-200 Physical Facility Design and Construction

6-201.13B

MN Rule 4626.1345B Provide a floor drain, properly grade the floor to drain to the floor drain and properly cove and seal wall/floor junctures when water flushing cleaning methods are used.

WATER FROM LEAKING DISHWASHER POOLING ON FLOOR RATHER THAN FLOWING TOWARD FLOOR DRAIN. MAINTAIN DRY. REPAIR FLOOR IF SANITARY CONDITIONS CANNOT BE MAINTAINED OR IF A REMODEL OCCURS.

Comply By: 02/24/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.16

MN Rule 4626.1540 Hang mops to dry after each use and do not store mops in a manner that will soil walls, equipment or supplies.

WET MOP NOT HUNG TO AIR DRY. REP INSTRUCTED TO HANG MOPS TO AIR DRY WHEN NOT IN USE.

Comply By: 02/24/25

Surface and Equipment Sanitizers

HOT WATER: = at 162 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

QUATERNARY AMMONIUM: = 300 ppm at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: AMBIENT/BUTTER PACKET
Temperature: 65 Degrees Fahrenheit - Location: ON COUNTER W/OUT TPHC
Violation Issued: Yes

Process/Item: AMBIENT/BUTTER
Temperature: 65-70 Degrees Fahrenheit - Location: SOFTENED BLOCK ON LINE W/OUT TPHC
Violation Issued: Yes

Process/Item: HOT HOLD/TURKEY
Temperature: 137 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: HOT HOLD/TURKEY
Temperature: 143 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: COLD HOLD/ALMOND MILK
Temperature: 39 Degrees Fahrenheit - Location: UNDER COUNTER COOLER
Violation Issued: No

Process/Item: COOLING/MILK
Temperature: 47 Degrees Fahrenheit - Location: JUST OUT FOR SERVICE COOLING BACK DOWN
Violation Issued: No

Process/Item: COOLING/MILK
Temperature: 46 Degrees Fahrenheit - Location: JUST OUT FOR SERVICE COOLING BACK DOWN
Violation Issued: No

Process/Item: COLD HOLD/BUTTER
Temperature: 39 Degrees Fahrenheit - Location: 3-DOOR UPRIGHT
Violation Issued: No

Process/Item: COLD HOLD/SPAGHETTI
Temperature: 39 Degrees Fahrenheit - Location: 3-DOOR UPRIGHT
Violation Issued: No

Process/Item: COLD HOLD/BUTTER
Temperature: 38 Degrees Fahrenheit - Location: 1-DOOR UPRIGHT
Violation Issued: No

Process/Item: COLD HOLD/SLICED HAM
Temperature: 41 Degrees Fahrenheit - Location: UNDER GRIDDLE COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	3	7

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 1029251057 of 02/24/25.

Certified Food Protection Manager: LORI ANN MCGUIRE

Certification Number: 124931 Expires: 09/03/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
CARMEN LARA
COOK

Signed: *Trevor McCliment*
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Food Establishment Inspection Report

Report #: 1029251057

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	3	**Date**	02/24/25
No. of Repeat RF/PHI Categories Out	2	**Time In**	13:00:46
Legal Authority MN Rules Chapter 4626		**Time Out**	

Personal Care Management Llc	**Address** 525 Cutter Street	**City/State** Anoka, MN	**Zip Code** 55303	**Telephone** 7633359590
License/Permit # 0037457	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		X
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		X
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R **COS=** corrected on-site during inspection **R=** repeat violation

		Safe Food and Water	COS	R
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

		Proper Use of Utensils	COS	R
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56	X	Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls: _____

Person in Charge (Signature) **Date:** 02/25/25

Inspector (Signature) *Trevor McCliment*