Electronically Delivered

November 15, 2024

Licensee
Allied Gardens Care LLC
3547 North 4th Street
Minneapolis, MN 55412

RE: Project Number(s) SL39886015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on October 10, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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

Per 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 residents/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39886	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIED GARDENS CARE LLC	3547 NORTH 4TH STREET MINNEAPOLIS, MN 55412

(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: SL39886015-0 On October 7, 2024, through October 10, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents; all receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 8, 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		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for	0 490		

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0 490	Continued From page 2 transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all nine residents of the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).	0 490		

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0 490	Continued From page 3 The findings include: During observations on October 7 and 8, 2024, the surveyor observed no activities were planned or offered to the residents. R1 and two other residents remained in their rooms most of the day. On October 8, 2024, at 12:00 p.m., when interviewed about daily activities, unlicensed personnel (ULP)-B replied, "We may take them out for shopping or watch TV". On October 10, 2023, at 3:30 p.m., licensed assisted living director (LALD)-C acknowledged an activity program had not been developed with the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical	0 800		

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0 800	Continued From page 4 environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on October 8, 2024, from 10:50 a.m. to 11:30 a.m., with licensed assisted living director (LALD)-C, the surveyor made the following observations of facility disrepair: There were several branches in piles in the back yard resident recreation area taking up space in most of the outdoor resident recreation area. There was a hole eroded two feet into the ground by the rain gutter down spout near the window well in the back yard. The rainwater downspout is required to direct rainwater away from the building to not cause erosion and water infiltration to the interior of the building. During an interview on October 8, 2024, at 11:30 a.m., LALD-C, stated they had contacted the building owner to remove the tree branches from the resident outdoor recreation area and reroute the rainwater down spout away from the building. TIME PERIOD FOR CORRECTION: Seven (7)	0 800		

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0 800	Continued From page 5 days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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.	0 810		

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0 810	Continued From page 6 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 required content, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 8, 2024, at 10:30 a.m., licensed assisted living director (LALD)-C, 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 licensee provided FSEP, failed to include the following: The evacuation floor plan map was posted on the main floor and the basement level, but the map posted in the basement was the same as the main floor layout. The evacuation floor plan map is required to be posted on each level and include accurate layout of each floor. The available FSEP did not identify specific fire protection actions for residents as evident by not	0 810		

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0 810	Continued From page 7 providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available 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 failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on October 8, 2024, at 10:40 a.m., LALD-C, stated the above requested documentation was not available. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by not providing documentation the required employee training was completed. During an interview on October 8, 2024, at 10:45 a.m., LALD-C, stated that training for staff was completed with the fire drills but not documented to indicate the FSEP required employee training was completed. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every	0 810		

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0 810	Continued From page 8 other month as evident by providing documentation evacuation drills were completed May 10, 2024, and August 14, 2024, only and no time of day or shift identified. No further information was provided. During an interview on October 8, 2024, at 10:50 a.m., LALD-C, stated evacuation drill documentation was available for May, and August, of 2024 only. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060		

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01060	Continued From page 9 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation 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 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).	01060		

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01060	Continued From page 10 The findings include: R1 was admitted on August 13, 2024. R1's diagnoses included diabetes. R1's Service Plan dated August 13, 2024, indicated R1 received services including medication assistance. R1's progress notes dated September 26, 2024, and October 1, 2024, noted R1 was admitted to the hospital on September 26, 2024, and returned to the facility on October 1, 2024. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that R1 had been relocated and had not returned to the facility within four days. On October 8, 2024, at 1:00 p.m., registered nurse (RN)-A stated they were not aware of the required a written notice, no residents who have	01060		

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01060	Continued From page 11 ever had an emergency relocation would have received the required content, and the OOLTC had not been notified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
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;	01530		

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01530	Continued From page 12 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for supervisors of direct-care staff employees with 120 hours of employment start date and direct-care employees within 160 hours of employment start date for two of two employees (registered nurse (RN)-A, (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, 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: RN-A RN-A was hired on February 22, 2023, to provide direct services to the licensee's residents. RN-A's record lacked documentation of the required 8 hours of dementia care training within 120 hours of employment start date. ULP-B ULP-B was hired April 23, 2024, to provide direct care services to residents. ULP-B's "Certificate Of Completion" dated April 23, 2024, indicated ULP-B has completed one (1) hour of continuing education in dementia, but lacked documentation of the required 8 hours of	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39886	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIED GARDENS CARE LLC	3547 NORTH 4TH STREET MINNEAPOLIS, MN 55412

(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
01530	Continued From page 13 dementia care training within 160 hours of employment start date. On October 9, 2024, at 3:00 p.m., licensed assisted living director (LALD)-C stated ULP-B and RN-A's employee records lacked documentation of the required 8 hours of dementia care training within 120 hours or 160 hours of employment start date. RN-A acknowledged the licensee was not aware of the required 8 hours of dementia care training for all assisted living facilities. The licensee's Dementia Education policy dated February 15, 2023, indicated supervisors of direct care staff will have at least eight (8) hours within 120 working hours of employment start date and direct care employees working in an assisted living facility with dementia care must have completed at least eight (8) hours within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, 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	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39886	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIED GARDENS CARE LLC	3547 NORTH 4TH STREET MINNEAPOLIS, MN 55412

(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
01750	Continued From page 14 in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the administration of resident medications was documented by unlicensed personnel (ULP) for one of one employee (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 of the residents). The findings include: ULP-B began employment on April 23, 2024, to provide direct care services to the licensee's residents, including medication administration. ULP-B's employee record indicated they had been trained on medication administration and passed a competency evaluation on May 10, 2024. On October 8, 2024, at 9:00 a.m., the surveyor observed ULP- B administer morning medications to R1. ULP-B removed R1's medication from a locked cabinet. R1's bi-weekly medication planner was organized with four rows; the first two rows labeled week one morning and night and the other two rows labeled week two morning and night; and on top indicated R1's name. ULP-B	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39886	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIED GARDENS CARE LLC	3547 NORTH 4TH STREET MINNEAPOLIS, MN 55412

(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
01750	Continued From page 15 found the correct day (Tuesday) and time (morning) and placed the medication into a medication cup and gave the medications to R1. ULP-B failed to reference or compare the medication given to R1's electronic medication administration record (EMAR) prior to administration. On October 8, 2024, at 9:45 a.m., ULP-B stated registered nurse (RN)-A set up medications and ULPs gave the medications to the residents from the medication organizers. ULP-B stated she was not sure what medications she was giving to R1. On October 8, 2024, at 1:00 p.m., RN-A stated the medication planner did not indicate what medications were in the medication planner and staff had no information to reference or compare to verify the EMAR before administering medications. RN-A stated she set up medications every two weeks to prevent medication error, but she planned to make changes to their system to include medication set up using a planner or using the bubble pack set up by the pharmacy. RN-A stated she would retrain all staff. The licensee's Staff Competency policy, dated February 15, 2023, indicated the clinical nurse supervisor is responsible for the overall competency evaluation program. Home health aides may not work for [Licensee] until they have successfully passed the written and demonstration competency evaluation, including administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39886	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIED GARDENS CARE LLC	3547 NORTH 4TH STREET MINNEAPOLIS, MN 55412

(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
01750	Continued From page 16 days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. In addition, the licensee failed to monitor a medication refrigerator according to the manufacturer's directions. 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: On October 8, 2024, at 12:30 p.m., the surveyor observed the unlocked refrigerator located in the kitchen and the contents of unlocked refrigerator included food, insulin, and the thermometer read 47 degrees Fahrenheit (°F). The following medications were not securely stored in the	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39886	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIED GARDENS CARE LLC	3547 NORTH 4TH STREET MINNEAPOLIS, MN 55412

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01880	Continued From page 17 refrigerator: - four unopened Humalog Kwik pen (injector device for insulin administration) - one opened Humalog Kwik pen On October 8, 2024, at 1:00 p.m., registered nurse (RN)-A acknowledged the insulin pens stored in the refrigerator in the kitchen were not securely locked, and unauthorized personnel have accessed the refrigerator. RN-A stated they received a new refrigerator for insulin medications and planned to implement its use starting today. Also, RN-A stated the licensee monitored refrigerator temperatures daily and if temperature was high or low, staff were trained to readjust it. Manufacturer's storage directions for Humalog Kwik pen revised April 2020, indicated, "Unused pens store in the refrigerator at 36°F to 46°F (2°C [degrees Celsius] to 8°C). Do not freeze your insulin. Do not use if it has been frozen. Unused pens may be used until the expiration date printed on the label, if the pen has been kept in the refrigerator." The licensee's Storage/Control of Medications policy dated February 15, 2023, indicated all prescription drugs would be kept securely locked in substantially constructed compartments according to the manufacturer's directions and only authorized staff would have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39886	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIED GARDENS CARE LLC	3547 NORTH 4TH STREET MINNEAPOLIS, MN 55412

(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
01890	Continued From page 18	01890		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an opened medication was dated correctly 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 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: On October 8, 2024, at 12:30 p.m., unlicensed personnel (ULP)-B prepared a Humalog Kwik pen (injector device for insulin administration) for administration according to the electronic medical record for R1. ULP-B verified the insulin pen should have been dated when opened it. The surveyor observed the opened insulin pen lacked a label of the date it was opened. On October 8, 2024, at 1:30 p.m., registered nurse (RN)-A acknowledged insulin pens should be dated at the time of opening. RN-A stated they	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39886	A. BUILDING: _____ B. WING _____	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIED GARDENS CARE LLC	3547 NORTH 4TH STREET MINNEAPOLIS, MN 55412

(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
01890	Continued From page 19 would retrain staff. The licensee's Medication Administration policy dated February 15, 2023, indicated [licensee] nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy. The manufacturer's instructions for Humalog dated July 2023, indicated "Do not use your Pen past the expiration date printed on the Label or for more than 28 days after you first start using the Pen." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Follow-Up
Date: *10/15/24*
Time: 10:35:17
Report: 1021241315

Food and Beverage Establishment Inspection Report

Location:
Allied Garden Cares
3547 N 4th Street
Minneapolis, MN55412
Hennepin County, 27

Establishment Info:
ID #: 0043695
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Temperature
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	0

TODAY'S FOLLOW UP WAS TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 10/08/24. 9 OUT OF 9 ORDERS WERE CLEARED FROM THE REPORT.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021241315 of 10/15/24.

Certified Food Protection Manager: YONIS SALAH

Certification Number: FM117917 Expires: 07/14/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
YONIS SALAH
OWNER/CFPM

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495

Food and Beverage Establishment Inspection Report

Melissa.Ramos@state.mn.us

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

Type: Full
Date: *10/08/24*
Time: 10:33:29
Report: 1021241299

Food and Beverage Establishment Inspection Report

Location:
Allied Garden Cares
3547 N 4th Street
Minneapolis, MN55412
Hennepin County, 27

Establishment Info:
ID #: 0043695
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

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

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

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH OWNER. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 10/09/24

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

THE CHLORINE ON-SITE IS NOT INTENDED FOR FOOD CONTACT SURFACES. STAFF WILL GET APPROVED CHLORINE TO USE IN THE KITCHEN. FACT SHEET WITH APPROVED FOOD CONTACT SANITIZERS SENT WITH REPORT.

Comply By: 10/09/24

7-200 Toxic Supplies and Applications

7-207.12 ***** Priority 1 *****

MN Rule 4626.1665 Store medicines that require refrigeration, belonging to employees or to children in a day care center, in container that is kept inside another covered, leakproof container that is identified as a container for medicine and located to be inaccessible to children.

INSULIN STORED IN THE WHIRLPOOL REFRIGERATOR WAS LOCATED IN THE DOOR

COMPARTMENT. STAFF BOUGHT A SMALL REFRIGERATOR TO STORE MEDICINES AWAY FROM FOOD. CORRECTED ON-SITE.

Comply By: 10/08/24

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.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN RESIDENTIAL DISH MACHINE. ONE THERMOLABEL LEFT ON-SITE TODAY. SEE COMMENTS.

Comply By: 10/15/24

4-300 Equipment Numbers and Capacities

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

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

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE.

Comply By: 10/15/24

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS IN THE KITCHEN HANDWASHING SINK. STAFF PROVIDED PAPER TOWELS DURING INSPECTION. CORRECTED ON-SITE. ENSURE THAT ALL HANDWASHING SINKS ARE STOCKED WITH PAPER TOWELS THROUGHOUT ALL HOURS OF OPERATION.

Comply By: 10/08/24

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 AN UNKNOWN CHEMICAL FOUND ON TOP OF THE KITCHEN REFRIGERATOR. STAFF WILL LABEL THE SPRAY BOTTLE WITH THE COMMON NAME OF THE PRODUCT AS DESCRIBED IN RULE ABOVE.

Comply By: 10/08/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

THE AMBIENT TEMPERATURE OF THE KITCHEN REFRIGERATOR MEASURED 47F. PER CONVERSATION WITH STAFF, THEY HAD THE FRIDGE OPEN FOR A WHILE TO CLEAN IT. STAFF WILL ADJUST THE TEMPERATURE OF THE COOLER OR HAVE IT SERVICED. SEE COMMENTS.

Comply By: 10/08/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASHING SINKS IN THE KITCHEN AND IN THE BATHROOM ARE MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH THEIR HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 10/10/24

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 49 Degrees Fahrenheit - Location: RELISH - WHIRLPOOL REFRIGERATOR
Violation Issued: Yes

Process/Item: Ambient Temperature
Temperature: 47 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: Yes

Process/Item: Cooking
Temperature: 211 Degrees Fahrenheit - Location: BEEF STEW - STOVE
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH OWNER, YONIS SALAH AND HEALTH REGULATION DIVISION NURSE EVALUATOR, SAFIA HASSAN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 3 CLIENTS AND THE FACILITY CAN HAVE UP TO 5 CLIENTS.

PER CONVERSATION WITH OWNER, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, PAINTED DRYWALL, AND VINYL FLOORING. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

Food and Beverage Establishment Inspection Report

CONTINUATION OF MN Rule 4626.0735AB
DISCUSSED WITH STAFF THAT THEY SHOULD NOT KEEP THE FRIDGE DOORS OPEN FOR A WHILE BECAUSE IT BRINGS UP THE AMBIENT TEMPERATURE.

CONTINUATION OF MN Rule 4626.0710B
STAFF ARE GOING TO RUN THE DISH MACHINE AND THEY ARE GOING SEND A PICTURE OF THE THERMOLABEL TO INSPECTOR TO MAKE SURE THE DISH MACHINE IS REACHING A FINAL UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F.

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 1021241299 of 10/08/24.

Certified Food Protection Manager: YONIS SALAH

Certification Number: FM117917 Expires: 07/14/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
YONIS SALAH
OWNER/CFPM

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us