



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 20, 2025

Licensee
Residential Care Nine Mile Crk
10641 James Road
Bloomington, MN 55431

RE: License Number 419507
Health Facility Identification Number (HFID) 32061
Project Number(s) SL32061015

Dear Licensee:

On January 15, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed July 24, 2024, and the follow-up survey completed on October 23, 2024. This follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective February 20, 2025.

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.

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

Sincerely,

A handwritten signature in black ink that reads "Rick Michals".

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 10, 2024

Licensee

Residential Care Nine Mile Creek

10641 James Road

Bloomington, MN 55431

RE: Conditional License Number 415411
Health Facility Identification Number (HFID) 32061
Project Number(s) SL32061015

Dear Licensee:

On October 23, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on July 24, 2024. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a conditional assisted living facility license for 90-days, due to expire on **March 10, 2025**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on July 24, 2024, found not corrected at the time of the October 23, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on October 23, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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 and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

CONDITIONAL LICENSE ISSUED:

MDH will issue a conditional assisted living facility license for Residential Care Nine Mile Creek, for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Residential Care Nine Mile Creek is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. **Egress Door Requirements:** Residential Care Nine Mile Creek will ensure that all doors leading to the exterior of the building provide a continuous means of egress without obstruction.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if Residential Care Nine Mile Creek is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Residential Care Nine Mile Creek is in substantial compliance on the follow up survey, MDH will remove the conditions from Residential Care Nine Mile Creek's assisted living facility license, and Residential Care Nine Mile Creek will correct any outstanding violations identified during the survey. If Residential Care Nine Mile Creek is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit:

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

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

If you have any questions, please contact Jess Schoenecker directly at: 651-201-3789.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/23/2024
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CARE NINE MILE CRK	STREET ADDRESS, CITY, STATE, ZIP CODE 10641 JAMES ROAD BLOOMINGTON, MN 55431
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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.</p> <p>INITIAL COMMENTS: SL32061015-1</p> <p>On October 22, 2024, through October 23, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on July 24, 2024. At the time of the survey, there were five residents; five receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.</p>	{0 000}	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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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: Not reviewed during this follow up survey.	{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: Not reviewed during this follow up survey.	{0 580}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure,	{0 650}		

Minnesota Department of Health

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{0 650}	Continued From page 2 registration, or certification if licensure, registration, or certification is required by this chapter or rules; (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: Not reviewed during this follow up survey.	{0 650}		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of	{0 660}		

Minnesota Department of Health

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{0 660}	Continued From page 3 the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this follow up survey.	{0 660}		
{0 820} SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. The licensee failed to provide means of egress from the facility that comply with the minimum egress requirements. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. This practice resulted in a level two violation (a	{0 820}		

Minnesota Department of Health

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{0 820}	<p>Continued From page 4</p> <p>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).</p> <p>The findings include:</p> <p>On October 22, 2024, at 10:30 a.m., the surveyor entered the facility for a follow-up survey and toured the facility with owner (O)-E. During the tour, O-E stated the means of egress had not been modified yet, and the licensee was in the process of installing a new egress door. O-E stated that the licensee maintained a continuous fire watch and provided the fire watch log.</p> <p>During the facility tour, the surveyor observed the following items:</p> <p>It was observed that the facility did not provide a continuous means of egress to the exterior of the building. The facility had converted a living room into a sleeping room, and the front entrance door was located within the sleeping room and was not accessible to use for an emergency egress exit. A privacy lock was installed on the egress side of the sleeping room door.</p> <p>It was also observed a door to the garage was identified as the only egress door from the main level in the posted evacuation plan.</p> <p>During an interview on October 22, 2024, at 11:00 a.m., O-E stated since the initial survey on July 23, 2024, the licensee decided to remove the existing window at the front porch and add a new front door to meet the egress code. The licensee</p>	{0 820}		

Minnesota Department of Health

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{0 820}	<p>Continued From page 5</p> <p>had been working with the Minnesota Department of Labor and Industry (DLI)-delegated city and received the permit for the work. The new door had been ordered and was ready to be installed. O-E stated the licensee started the process right after the initial survey but was delayed by the DLI permitting process.</p> <p>During the same interview, the surveyor explained to O-E that the facility is required to provide means of egress to the exterior, and obstruction of egress was a distinct hazard to life.</p> <p>On October 22, 2024, at 11:30 a.m., the surveyor explained to O-E that the order would be reissued due to continued non-compliance with previous correction orders but would be reissued at a lower level due to the current progress and the licensee maintaining a continuous fire watch. O-E acknowledged the above findings.</p>	{0 820}		
{01290} SS=F	<p>144G.60 Subdivision 1 Background studies required</p> <p>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p>	{01290}		

Minnesota Department of Health

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{01290}	Continued From page 6 This MN Requirement is not met as evidenced by: Not reviewed during this follow up survey.	{01290}		
{01440} SS=F	<p>144G.62 Subd. 4 Supervision of staff providing delegated nurs</p> <p>(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 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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Not reviewed during this follow up survey.</p>	{01440}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/23/2024
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{01620}	<p>Continued From page 7</p> <p>(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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Not reviewed during this follow up survey.</p>	{01620}		
{01760} SS=D	<p>144G.71 Subd. 8 Documentation of administration of medication</p> <p>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of</p>	{01760}		

Minnesota Department of Health

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{01760}	Continued From page 8 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Not reviewed during this follow up survey.	{01760}		
{01820} SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Not reviewed during this follow up survey.	{01820}		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 22, 2024

Licensee
Residential Care Nine Mile Creek
10641 James Road
Bloomington, MN 55431

RE: Project Number(s) SL32061015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - \$3,000.00

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CARE NINE MILE CRK	STREET ADDRESS, CITY, STATE, ZIP CODE 10641 JAMES ROAD BLOOMINGTON, MN 55431
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL32061015-0</p> <p>On July 22, 2024, through, July 24, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six (6) residents receiving services under the provider's Assisted Living Facility license.</p> <p>On July 23, 2024, an immediate correction order was issued for tag identification 0470.</p> <p>The immediacy of tag identification 0470 was not removed prior to exit.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 470 SS=G	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for</p>	0 470		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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0 470	<p>Continued From page 1</p> <p>determining its staffing level that:</p> <ul style="list-style-type: none"> (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; <p>(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:</p> <ul style="list-style-type: none"> (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; <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to meet the scheduled and reasonably foreseeable unscheduled needs of the residents as required per Minnesota Administrative Rules 4659.0180.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,</p>	0 470	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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</p>	
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Minnesota Department of Health

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0 470	<p>Continued From page 2</p> <p>or a violation that has the potential to lead to 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).</p> <p>The findings include:</p> <p>On July 23, 2024, at 8:15 a.m., during continuous observations, both unlicensed personnel (ULP)-A and owner (O)-E assisted R1 with a transfer from their bed to their wheelchair with the use of a gait belt (a belt-like device placed around a person's body to allow another person to hold and assist with transfers or mobility). ULP-A and O-E needed to use multiple verbal commands and physical directional assistance with the gait belt to safely move R1 from the bed to the wheelchair.</p> <p>R1 was admitted on June 30, 2018.</p> <p>R1's me (sic) Health Communication Note dated June 14, 2024, was identified by clinical nurse supervisor (CNS)-D as R1's physical therapy (PT) orders provided by R1's third party home health company. The PT order read, "Please cont [continue] Ax2 [assist of two] and gait belt for tx [transfer]," and was signed by the physical therapist who placed the order.</p> <p>R1's Individual Abuse Prevention Plan assessment dated July 12, 2024, indicated R1 was not able to safely ambulate (term used for a person's ability to walk or move) on their own and indicated staff would utilize a gait belt for ambulation.</p> <p>R1's Uniform Assessment Tool form dated July 12, 2024, was indicated by CNS-D as R1's most</p>	0 470	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health

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0 470	<p>Continued From page 3</p> <p>recent comprehensive assessment. The assessment indicated on page 19 of 21, R1 did not use any transfer devices and was an assist of one (1), in contrast to the PT order dated June 14, 2024.</p> <p>R1's undated [resident's name] document was identified by CNS-D as R1's current care plan. On page two (2) of the care plan it read, "Transfers - Dependent 2 Staff As of: 6.20.2024 [June 20, 2024], Assist resident up with assist of 2 staffs. Use gait belt and wheelchair for mobility."</p> <p>The licensee's Weekly Work Schedule dated for the week ending July 28, 2024, indicated the licensee staffed one (1) ULP during the overnight shift scheduled from 10:00 p.m. to 7:00 a.m.</p> <p>On July 23, 2024, at 11:20 a.m., O-E stated the licensee only scheduled 1 ULP on the overnight shift. CNS-D stated the licensee was not aware of Minnesota Administrative Rules 4659.0180. CNS-D stated the licensee would need find an additional person to work the overnight shift as R1 required 2 direct care staff for all transfers. CNS-D stated the licensee would contact PT to reassess R1 to ensure accurate transfer requirements and instructions were developed and implemented as ordered.</p> <p>The licensee's 4.06 Staffing and Scheduling policy dated June 30, 2021, indicated the licensee would schedule for residents' scheduled and reasonable foreseeable unscheduled needs, but the policy failed to identify the licensee would schedule 2 staff for all shifts when a resident required 2 staff assistance.</p> <p>Minnesota Administrative Rules 4659.0180 dated August 11, 2021, indicated under Staffing subpart</p>	0 470		

Minnesota Department of Health

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0 470	<p>Continued From page 4</p> <p>five (5), "Direct-care staff availability. A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan."</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p> <p>The immediacy of tag identification 0470 was not removed prior to exit.</p>	0 470		
0 480 SS=F	<p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(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</p> <p>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.</p> <p>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).</p>	0 480		

Minnesota Department of Health

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0 480	Continued From page 5 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 22, 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		
0 580 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 implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors.	0 580		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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0 580	<p>Continued From page 6</p> <p>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).</p> <p>The findings include:</p> <p>On July 22, 2024, at 10:00 a.m., during the entrance conference, owner (O)-E and clinical nurse supervisor (CNS)-D stated the licensee failed to develop, implement, and maintain a quality management program. O-E stated the licensee had an informal project to improve how the licensee provided services, but no evidence of tracking or meeting minutes would be available to review.</p> <p>The licensee's 2.31 Quality Management Project policy dated June 30, 2021, indicated the licensee would develop and document a quality management program and documentation of the program would be made available upon request of the Minnesota Department of Health.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 580		
0 650 SS=D	<p>144G.42 Subd. 8 Employee records</p> <p>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must</p>	0 650		

Minnesota Department of Health

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0 650	<p>Continued From page 7</p> <p>include the following information:</p> <p>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;</p> <p>(2) records of orientation, required annual training and infection control training, and competency evaluations;</p> <p>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;</p> <p>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;</p> <p>(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</p> <p>(6) documentation of the background study as required under section 144.057.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained all required content for one of two employees (unlicensed personnel (ULP)-B).</p> <p>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).</p> <p>The findings include:</p>	0 650		

Minnesota Department of Health

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0 650	<p>Continued From page 8</p> <p>ULP-B was hired on May 19, 2019.</p> <p>ULP-B's record lacked evidence the licensee provided competency evaluation training to ULP-B.</p> <p>On July 23, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-D stated they had trained ULP-B in all required areas and had completed competency testing with ULP-B. CNS-D stated the licensee had multiple locations the documented evidence could have been stored, but the licensee was unable to locate evidence of the provided training and competencies. CNS-D stated ULP-B's record would need to be audited to ensure all required training was accurately documented and evidence maintained in ULP-B's record.</p> <p>The licensee's 4.05 Employee Records policy dated June 30, 2021, indicated each employee's record would include all evidence of training, orientation, and competency testing completed.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 650		
0 660 SS=D	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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0 660	<p>Continued From page 9</p> <p>and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a negative IGRA (serum blood test) or two-step Mantoux tuberculin skin test (TST) dated within 90 days of hire for one of two employees (unlicensed personnel (ULP)-B).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-B was hired on May 19, 2019.</p> <p>ULP-B's Baseline TB Screening Tool for Health Care Workers (HCWs) dated February 24, 2021, included a TST - first step results dated February 26, 2021. The TST - second step section was left</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 660	<p>Continued From page 10</p> <p>blank.</p> <p>On July 23, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-D stated ULP-B should have had a second step TST completed. CNS-D was not sure why the second step was missed as it is required for all employees to have a two-step Mantoux TST or blood test completed. CNS-D stated ULP-B would be sent to get a blood test completed immediately.</p> <p>The licensee's 4.05 Employee Records policy indicated each employee's record would include results of completed required health screenings for TB.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 810 SS=F	<p>144G.45 Subd. 2 (b)-(f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p> <ul style="list-style-type: none"> (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. <p>(c) Employees of assisted living facilities shall</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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0 810	<p>Continued From page 11</p> <p>receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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0 810	<p>Continued From page 12</p> <p>On July 23, 2024, at 2:00 p.m., the owner (O)-E provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.</p> <p>EMERGENCY EVACUATION PLAN On July 23, 2024, at 1:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-C and owner(O)-E. During the facility tour, survey staff observed the following discrepancies in the posted emergency evacuation plan:</p> <p>The posted emergency evacuation plan did not show the number of resident rooms.</p> <p>The posted emergency evacuation plans were not accurate depictions of the egress route and did not match the current layout of the resident rooms, as indicated by the following observations:</p> <ul style="list-style-type: none"> - The resident sleeping room 6 on the lower level was identified as an office in the posted evacuation plan. - The resident sleeping room 5 on the lower level did not have accurate depictions of the egress route and wall locations. It was also observed that a portion of the room was identified as bedroom 6 in the posted evacuation plan. - The posted main-level evacuation plan indicated that the emergency evacuation route from the living room to the exterior of the building was routed through resident sleeping room 1. <p>During the interview on July 23, 2024, at 2:30 p.m., O-E stated the resident sleeping room 1 was not an egress exit from the main level, and confirmed the posted evacuation plan was not an accurate depiction of the current layout of the facility.</p>	0 810		

Minnesota Department of Health

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0 810	<p>Continued From page 13</p> <p>TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire.</p> <p>During the interview on July 23, 2024, at 2:30 p.m., O-E stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. O-E confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute.</p> <p>DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift as required by statute. The provided documentation indicated that drills were conducted only for the first and second shifts, and the facility failed to provide two drills for the third shift.</p> <p>During the interview on July 23, 2024, at 2:30 p.m., O-E stated the facility did not conduct two drills for the night shift and verified there were no further documented drills for the facility.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 810		
0 820 SS=I	<p>144G.45 Subd. 2 (g) Fire protection and physical environment</p> <p>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be</p>	0 820		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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0 820	<p>Continued From page 14</p> <p>permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. The licensee failed to provide means of egress from the facility that comply with the minimum egress requirements. This had the potential to affect all occupied residents, staff, and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).</p> <p>The findings include:</p> <p>On July 23, 2024, at 1:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-C and owner(O)-E. During the facility tour, survey staff observed the following items:</p>	0 820		

Minnesota Department of Health

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0 820	<p>Continued From page 15</p> <p>It was observed that the facility did not provide a continuous means of egress to the exterior of the building. In the posted main-level evacuation plan, the main entrance door was identified as an emergency egress exit, but the main entrance door was not accessible from the main level to use as an emergency egress exit.</p> <p>The facility converted a living room into a sleeping room, and the front entrance door was located within the added sleeping room. A privacy lock was installed on the egress side of the sleeping room door. It was also observed a door to the garage was identified as the only egress door from the main level in the posted evacuation plan.</p> <p>During the interview on July 23, 2024, at 1:30 p.m., O-E stated that the facility had converted the living room to a bedroom about four years ago without obtaining the necessary building permits from the municipalities having jurisdiction. O-E also confirmed that the garage door was the main entrance to the facility and the only emergency egress door from the main floor.</p> <p>During the same interview, survey staff explained to O-E that the facility is required to provide means of egress to the exterior, and obstruction of egress was a distinct hazard to life. O-E stated he understood the deficiency and would consult with the municipalities having jurisdiction to ensure the facility was in compliance.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 820		
01290 SS=F	144G.60 Subdivision 1 Background studies required	01290		

Minnesota Department of Health

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01290	<p>Continued From page 16</p> <p>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a Department of Human Services (DHS) background study (BGS) was associated with the licensee's current assisted living facility's health facility identification (HFID) number for two of two unlicensed personnel ((ULP)-A, ULP-B).</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's current assisted living HFID was 32061.</p>	01290		

Minnesota Department of Health

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01290	<p>Continued From page 17</p> <p>ULP-A and ULP-B were hired on September 11, 2020, and May 19, 2019, respectively.</p> <p>ULP-A's DHS BGS dated September 9, 2020, was associated with HFID 31979 (the licensee's previously held 144A Home Care license).</p> <p>ULP-B's DHS BGS dated May 21, 2019, was associated with HFID 31979.</p> <p>On July 22, 2024, at 11:15 a.m., licensed assisted living director (LALD)-C stated the licensee had not associated ULP-A and ULP-B with the licensee's current HFID. LALD-C stated both ULPs had a cleared BGS, and the licensee was not aware ULP-A and ULP-B would need to be associated with the new HFID. LALD-C stated the licensee would associate both ULPs immediately to ensure compliance and would audit all employee records to ensure each employee had the correct HFID affiliation.</p> <p>The licensee's 4.02 Background Studies policy dated June 30, 2021, indicated each employee would have a cleared BGS but the policy failed to indicate each employee's BGS would be associated with licensee's current HFID.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	01290		
01440 SS=F	<p>144G.62 Subd. 4 Supervision of staff providing delegated nurs</p> <p>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an</p>	01440		

Minnesota Department of Health

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01440	<p>Continued From page 18</p> <p>appropriate licensed health professional or a registered nurse according to the assisted living 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.</p> <p>(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.</p> <p>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 supervision of an unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for two of two ULPs (ULP-A, ULP-B).</p> <p>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).</p>	01440		

Minnesota Department of Health

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01440	<p>Continued From page 19</p> <p>The findings include:</p> <p>ULP-A and ULP-B were hired on September 11, 2020, and May 19, 2019, respectively.</p> <p>On July 22, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-D provided ULP-A and ULP-B's employee records and indicated all required content would be included. ULP-A and ULP-B's records lacked evidence of a 30-day supervision for delegated tasks. CNS-D stated the licensee failed to complete a 30-day supervision by a RN for delegated task. CNS-D stated the licensee was not aware of the 30-day supervision requirement and would need to audit each employee's record to ensure a 30-day supervision was completed and documented for ULPs who had delegated tasks.</p> <p>The licensee's 4.05 Employee Records policy dated June 30, 2021, indicated each employee's record would include all evidence of training and competencies completed with each ULP.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01440		
01620 SS=F	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(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</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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01620	<p>Continued From page 20</p> <p>from the last date of the assessment.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an accurate comprehensive nursing assessment of the physical needs for one of one resident (R1).</p> <p>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).</p> <p>The findings include:</p> <p>On July 22, 2024, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-A and</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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01620	<p>Continued From page 21</p> <p>owner (O)-E transfer R1 from their bed to their wheelchair. R1 required the assistance of two (Ax2) with a gait belt (a sturdy belt placed around the waist to aid in safe transfers) as R1 was unsteady on their feet and unable to safely move from their bed to their wheelchair without assistance.</p> <p>R1 was admitted on June 30, 2018.</p> <p>R1's [primary care company name] Order dated May 24, 2024, read R1 would continue skilled physical therapy (PT), "to improve deficits in BLE [bilateral lower extremities or both lower legs] strength, balance, and gait impacting falls risk and safe/independent household mobility."</p> <p>R1's me [sic] Health Communication Note dated June 14, 2024, was identified by clinical nurse supervisor (CNS)-D as R1's physical therapy orders provided by R1's third party home health company. The PT order read, "Please cont [continue] Ax2 and gait belt for tx [transfer]," and was signed by the physical therapist who placed the order.</p> <p>R1's Uniform Assessment Tool form dated July 12, 2024, was indicated by CNS-D as R1's most recent comprehensive assessment completed by the registered nurse. The assessment indicated on page 19 of 21, R1 did not use any transfer devices and was an assist of one (1), in contrast to the PT order dated June 14, 2024.</p> <p>On July 23, 2024, at 11:00 a.m., CNS-D stated R1's most recent assessment was not accurate to R1's current transfer and mobility needs. CNS-D stated a new assessment would need to be completed to reflect R1's Ax2 for transfers and all current mobility devices. CNS-D stated they</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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01620	<p>Continued From page 22</p> <p>were the one who completed the most recent assessment and had missed updating the assessment when there was a change in order from PT for the Ax2 with gait belt for all transfers.</p> <p>The licensee's 6.01 Assessments, Reviews & Monitoring policy dated June 30, 2021, indicated each resident would have an assessment completed in person by a registered nurse and would include all required areas.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01620		
01760 SS=D	<p>144G.71 Subd. 8 Documentation of administration of medication</p> <p>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CARE NINE MILE CRK	STREET ADDRESS, CITY, STATE, ZIP CODE 10641 JAMES ROAD BLOOMINGTON, MN 55431
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	<p>Continued From page 23</p> <p>one of one resident (R1) who received medication management.</p> <p>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).</p> <p>The findings include:</p> <p>On July 23, 2024, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-A provide medication administration to R1. ULP-A obtained R1's oral pills from a locked medication cabinet and dispensed R1's medications while in the common kitchen area. ULP-A placed each oral pill in a medication crusher (a device used to crush pills into a powder) and crushed the pills. ULP-A poured the crushed medications into a paper medication cup and took the crushed medications to R1. After ULP-A left the common kitchen area and administered the medications to R1, a pile of crushed medications was noted on the counter where ULP-A had poured the crushed medications from the pill crusher into the paper cup.</p> <p>On July 23, 2024, at 9:00 a.m., clinical nurse supervisor (CNS)-D was directed to pile of crushed medications on the kitchen counter. CNS-D stated ULP-A should have notified CNS-D when the medications spilled. CNS-D stated ULP-A would have been directed to destroy all the medications that were crushed, and new oral pills dispensed as there was no safe manner to</p>	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CARE NINE MILE CRK	STREET ADDRESS, CITY, STATE, ZIP CODE 10641 JAMES ROAD BLOOMINGTON, MN 55431
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	<p>Continued From page 24</p> <p>identify which medications were spilled and not administered as ordered. CNS-D stated the situation that occurred would be a medication error and an incident report would need to be completed with all required content per the licensee's policy.</p> <p>The licensee's 7.07 Medication Loss or Spillage policy dated June 30, 2021, indicated when a medication was spilled, the registered nurse would be contacted, and a medication error form would be completed.</p> <p>The licensee's 7.24 Medication Error policy dated June 30, 2021, indicated when a medication error occurred, the registered nurse would be contacted, and the registered nurse would contact the resident's primary care provider to obtain directions and orders to be implemented.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01760		
01820 SS=F	<p>144G.71 Subd. 13 Prescriptions</p> <p>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were maintained for one of one resident (R1).</p>	01820		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CARE NINE MILE CRK	STREET ADDRESS, CITY, STATE, ZIP CODE 10641 JAMES ROAD BLOOMINGTON, MN 55431
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01820	<p>Continued From page 25</p> <p>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).</p> <p>The findings include:</p> <p>R1 was admitted June 30, 2018.</p> <p>R1's Care Plan dated May 10, 2024, read under Care Item 21 R1 required, "Medication - Assistance Administer medication per MD (medical doctor) orders," three times per day.</p> <p>R1's [licensee] Assisted Living License Resource Manual - 6.09 document signed May 16, 2024, identified by clinical nurse supervisor (CNS)-D as R1's service plan, indicated R1 required Medication Administration daily.</p> <p>R1's Medication Administration Report (MAR) dated for July 2024, indicated R1 received medication administration for 14 unique medications every day.</p> <p>On July 23, 2024, at 12:45 p.m., CNS-D provided five (5) signed primary care provider's (PCP) orders for R1. CNS-D stated the licensee did not maintain signed orders for each medication R1 received. CNS-D stated the licensee thought R1's pharmacy would maintain the signed orders as the pharmacy was sending the medications to the facility, but the licensee did not keep a signed copy of each medication administered for any resident. CNS-D stated R1's PCP would often</p>	01820		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32061	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2024
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NAME OF PROVIDER OR SUPPLIER RESIDENTIAL CARE NINE MILE CRK	STREET ADDRESS, CITY, STATE, ZIP CODE 10641 JAMES ROAD BLOOMINGTON, MN 55431
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01820	<p>Continued From page 26</p> <p>send orders directly to the pharmacy and the licensee would not obtain a copy of the signed order. CNS-D stated the licensee would contact each resident's PCP and obtain current orders for all medications each resident was administered.</p> <p>The licensee's 7.18 Medication & Treatment Orders - Renewal policy dated June 30, 2021, indicated every medication administered by the licensee would have a current physician prescription in each resident record.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01820		

Type: Full
Date: 07/22/24
Time: 12:15:00
Report: 1031241175

Food and Beverage Establishment Inspection Report

Page 1

Location:

Residential Care Nine Mile Crk
10641 James Road
Bloomington, MN55431
Hennepin County, 27

Establishment Info:

ID #: 0038215
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522294213
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

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

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

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 07/25/24

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.

IRREVERSIBLE MEASURING DEVICE IS NOT FUNCTIONAL. PROVIDE IRREVERSIBLE MEASURING DEVICE TO MEASURE UTENSIL TEMPERATURE(160F REQUIRED) IN DISH MACHINE. DO NOT PLACE THERMOMETER IN BAGGY. CHECK AT REGULAR INTERVALS.

Comply By: 07/25/24

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.

ESTABLISHMENT DOES NOT HAVE BLEACH SANITIZER TESTING KIT ON SITE. PURCHASE KIT AND TEST SANI CONCENTRATION (50-200PPM) WHEN USING BLEACH.

Comply By: 07/25/24

Type: Full
Date: 07/22/24
Time: 12:15:00
Report: 1031241175
Residential Care Nine Mile Crk

Food and Beverage Establishment Inspection Report

Page 2

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
ESTABLISHMENT HAS 3 LOCATIONS AND 1 CFPM HOLDER. HAVE ANOTHER EMPLOYEE COMPLETE THE CFPM CERTIFICATION.

Comply By: 08/12/24

5-500 Refuse and Recyclables

5-501.16C

MN Rule 4626.1255C Provide a waste receptacle at each handwashing sink or group of handwashing sinks if disposable towels are used.

HANDSINK/KITCHEN WASTE RECEPTACLE HAS LID THAT NEEDS TO BE LIFTED BY HAND - CONTAMINATION RISK. REMOVE LID FROM WASTE RECEPTACLE OR PURCHASE WASTE RECEPTACLE WITH FOOT PETAL.

Comply By: 08/12/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

1. LOWER CORNER CABINET HAS WALL MISSING SHEETROCK WITH EXPOSED INSULATION AND STUDS. REPAIR WALL.
2. CABINET UNDER SINK HAS HOLD BY ELECTRICAL. SEAL HOLE.
3. CONTACT PAPER IN CUPBOARDS IS COMING OFF. REPLACED DAMAGED CONTACT PAPER.

Comply By: 08/12/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

AREA BELOW SINK HAS PEST DROPPINGS. REMOVE ALL ITEMS, CLEAN AREA, AND SEAL ANY HOLES. cONTACT PEST COMPANY IF PEST PROBLEM PERSISTS.

Comply By: 08/12/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

KITCHEN FLOOR IS STICKY/TACKY. CLEAN FLOOR AND LET DRY. IF STILL STICKY/TACKY, RECLEAN FLOOR UNTIL STICKY IS GONE.

Comply By: 07/23/24

Food and Equipment Temperatures

Type: Full
 Date: 07/22/24
 Time: 12:15:00
 Report: 1031241175

Food and Beverage Establishment Inspection Report

Residential Care Nine Mile Crk

Process/Item: Cold Hold/Milk

Temperature: 38 Degrees Fahrenheit - Location: Refrigerator

Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	3	5

Nurse Evaluator on site: Brandon Mueller

All violations discussed with Amin during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.
- Staff must prepare bleach sanitizer bucket or squirt bottle daily. Check concentration with test strips (50-200ppm Chlorine) when preparing solution. Use of the Briotech sanitizer at full concentration is also APPROVED for all food contact surfaces.
- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.
- Store all chemicals under sink.
- Make sure to datemark any prepared cold items that are kept in refrigerator.
- Cutting boards should be utilized as food contact surfaces and not counters or plates.
- - Establishment needs to check dish washer utensil temperature weekly (160F required) and record in log. If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with bleach (do not use Briotech sanitizer for this) sanitizer solution to sanitize dishes then air dry, as discussed during inspection.
- Facility has separate handwashing sink.
- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

Disinfectant Product is APPROVED for all food contact surfaces.

https://www3.epa.gov/pesticides/chem_search/ppls/093108-00001-20220513.pdf

AQUAVERT

EPA Registration Number: 93108-1

Company Name: BRIOTECH INC.

Address: 1102 SHUKSAN WAY

City, State Zip: EVERETT, WA 98203

First Registered Date: SEPTEMBER 23, 2014

Current Status (Date): Registered (SEPTEMBER 23, 2014)

Restricted Use: NO

Type: Full
Date: 07/22/24
Time: 12:15:00
Report: 1031241175
Residential Care Nine Mile Crk

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Environmental Health inspection report number 1031241175 of 07/22/24.

Certified Food Protection Manager: Abdifatah H Mohamed

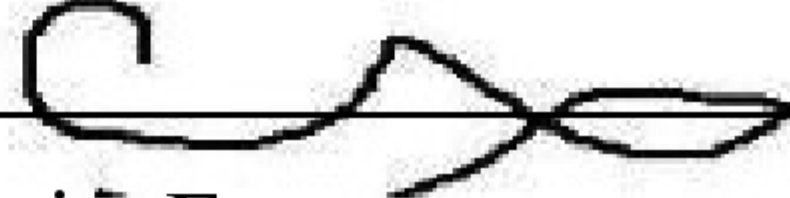
Certification Number: FM119617 Expires: 11/06/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Mohamed Amin
Person in Charge

Signed: _____


Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us