Electronically Delivered

December 28, 2022

Licensee
Cardenas Friendship House
1226 Wilderness Run Road
Eagan, MN 55123

RE: Project Number(s) SL21118015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 1, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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.

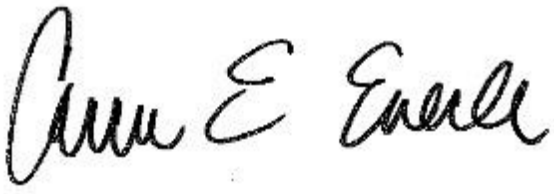
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Carrie Euerle, Interim Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-201-5984 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21118	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDENAS FRIENDSHIP HOUSE	1226 WILDERNESS RUN ROAD EAGAN, MN 55123

(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 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 #SL21118015 On November 29, 2022, through December 1, 2022, the Minnesota Department of Health conducted a Change of Ownership survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four resident receiving services under the provider's Assisted Living license.	0 000	Assisted Living Provider 144G. 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 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.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 included document titled, Food and Beverage Establishment Inspection Report	0 480		

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0 480	Continued From page 2 dated November 30, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation on quality management activities appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 580		

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0 580	Continued From page 3 of the residents). Findings include: During an interview on December 1, 2022, at 1:00 p.m., a copy of the facility's quality management plan was requested. The licensed assisted living administrator (LALD)-A verified not having a documented quality management activity. The licensee's Quality Management Project policy dated August 1, 2021 stated Cardenas Friendship Homes will have at least one documented quality management project in place at all times and retain records of such projects for at least two years. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 580		
0 650 SS=F	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, 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;	0 650		

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0 650	Continued From page 4 (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. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two unlicensed personnel (ULP)-D, ULP-E) with employee records reviewed. 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). Findings include: ULP-D's employee record indicated a hired date of January 1, 2022.	0 650		

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0 650	Continued From page 5 ULP-E's employee record indicated hired on August 24, 2022. ULP-D's employee record was reviewed and the signed employee orientation checklist record lacked evidence of: - orientation records - annual training records - infection control training - performance review -competency evaluations ULP-D's record also lacked evidence of Tuberculosis (TB) training. ULP-D's employee record also lacked evidence that ULP-D completed all the required training and demonstrated competency in the following topics: - appropriate and safe techniques in personal hygiene and grooming - hair care and bathing - care of teeth, gums, and oral prosthetic devices - dressing and assisting with toileting - standby assistance techniques and how to perform them - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning ULP-E's employee record was reviewed and the signed employee orientation checklist record lacked evidence of: -orientation records -annual training records - infection control training -performance review -competency evaluations	0 650		

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0 650	Continued From page 6 ULP-E's employee record also lacked Tuberculosis (TB) training. ULP-E's employee record lacked evidence ULP-D completed all the required training and demonstrated competency in the following topics: - appropriate and safe techniques in personal hygiene and grooming - hair care and bathing - care of teeth, gums, and oral prosthetic devices - dressing and assisting with toileting - standby assistance techniques and how to perform them - reading and recording temperature, pulse, and respirations of the client - safe transfer techniques and ambulation - range of motion and positioning During an interview of December 1, 2022 registered nurse (RN)-C verified ULP-D and ULP-E's personnel records did not include the above information, competencies or training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790		

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0 790	Continued From page 7 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, the licensee failed to ensure installation and maintenance of portable fire extinguishers at the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a violation that did not harm a resident's health or safety and was issued at a widespread scope. The findings include: On November 30, 2022, from approximately 1:00pm to 1:45pm, survey staff toured the facility with LALD-COB. During the facility tour, survey staff observed the fire extinguisher in the kitchen has not been inspected and tested last in December 2020. On November 30, 2022, from approximately 1:00pm to 1:45pm, survey staff toured the facility with LALD-COB. During the facility tour, survey staff observed the fire extinguisher in the kitchen was sitting on the floor and not hanging in a bracket. LALD-COB verbally confirmed survey staff observations during the facility tour. LALD-COB stated they will get the fire extinguisher serviced ASAP. No further information provided.	0 790		

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0 790	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
01430 SS=F	144G.62 Subd. 3 Supervision of staff (a) Staff who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be supervised periodically where the services are being provided to verify that the work is being performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. The supervision of the unlicensed personnel must be done by staff of the facility having the authority, skills, and ability to provide the supervision of unlicensed personnel and who can implement changes as needed, and train staff. (b) Supervision includes direct observation of unlicensed personnel while the unlicensed personnel are providing the services and may also include indirect methods of gaining input such as gathering feedback from the resident. Supervisory review of staff must be provided at a frequency based on the staff person's competency and performance. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation for two of two unlicensed personnel (ULP)-D and ULP-E) records reviewed for direct supervision of unlicensed personnel. This had the potential to affect all four residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01430		

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01430	Continued From page 9 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). Findings include: ULP-D's employee record indicated a hired date of January 1, 2022. ULP-E's employee record indicated hired on August 24, 2022. Neither employee record included documentation of direct supervision to verify the ULP performed services and cares competently and/or to identify problems and solutions to address issues relating to the staff's ability to provide the services. Tasks or procedures listed included: -Documentation requirements for all services provided -Report changes of changed in resident's condition to the supervisor -Basic infection control, including blood-borne pathogens -Maintenance of a clean and safe environment -Appropriate and safe techniques in personal hygiene and grooming including: hair care, bathing, care of teeth, gums, oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting. -Training on the prevention of falls -Standby assistance techniques and how to perform them -Basic nutrition, meal preparation, food safety -Communication skills that include preserving the dignity of the resident and showing respect for the	01430		

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01430	Continued From page 10 resident and the resident's preferences, cultural background, and family -Awareness of confidentiality and privacy -Understanding appropriate boundaries between staff and residents and the resident's family -Procedures to use in handling various emergency situations During an interview of December 1, 2022 registered nurse (RN)-C verified the requested records did not exist and the employee records did not include this information or supervision documents. The Assisted Living License, 5.02 Competency Training Evaluations policy, dated August 2, 2021, indicated when a registered nurse or licensed health professional staff delegates task, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	01430		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the	01500		

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01500	Continued From page 11	01500		

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

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01500	Continued From page 12	01500		

challenges it poses to communication;
(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or
(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of two unlicensed personnel (ULP-D) records reviewed. This had the potential to affect all four residents.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an 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).

Findings include:

ULP-D's employee record indicated a hired date of January 1, 2022. ULP-D's training transcript includes online training classes ending on August 4, 2021, no other classes were recorded after that date. ULP-D's record lacked evidence of receiving at least a minimum 8 hours of training

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21118	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDENAS FRIENDSHIP HOUSE	1226 WILDERNESS RUN ROAD EAGAN, MN 55123

(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
01500	Continued From page 13 per 12 months of employment. ULP-D's file lacked evidence ULP-D completed annual training for 2022 to include the following content: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On November 30, 2022 during the entrance conference, licensed assisted living director (LALD)-A as well as Co-Owner (CO)-B affirmed knowledge of the current assisted living laws and regulations. CO-B stated each employee had an individual personnel files that included orientation and training documentation and was not aware of	01500		

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	21118	A. BUILDING: _____ B. WING _____	12/01/2022

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01500	Continued From page 14 any other trainings documented elsewhere. During an interview of December 1, 2022 registered nurse (RN)-C verified the requested records did not exist and ULP-D's record did not include this information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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	01530		

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	21118	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDENAS FRIENDSHIP HOUSE	1226 WILDERNESS RUN ROAD EAGAN, MN 55123

(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 15 hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure completion and documentation of two of two unlicensed personnel (ULP-D and ULP-E) records of required dementia training. This had the potential to affect all four residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: ULP-D's employee record indicated a hired date of January 1, 2022. ULP-E's employee record indicated hired on August 24, 2022. ULP-D's training transcript includes online training classes ending on August 4, 2021, no other classes were recorded after that date. ULP-D's employee record lacked evidence of receiving at least eight hours total for dementia training within of a total 160 working hours as required. ULP-E's training transcript includes online training class Dementia 1 - Introduction and Overview that was completed on September 9, 2022, for 1 contact hour. No other dementia classes were	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21118	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDENAS FRIENDSHIP HOUSE	1226 WILDERNESS RUN ROAD EAGAN, MN 55123

(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 16 noted. The licensee's Assisted Living Dementia Training policy indicated direct care staff would complete a minimum of eight hours of initial training on dementia care topics within 160 working hours of the employment start date and the training would include the topics of an explanation of Alzheimer's disease and other dementia's, assistance with activities of daily living, problem solving with challenging behaviors, communication skills and person-centered planning and service delivery. On November 30, 2022 during the entrance conference, licensed assisted living director (LALD)-A as well as Co-Owner (CO)-B affirmed knowledge of the current assisted living laws and regulations. CO-B stated each employee had an individual personnel files that included orientation and training documentation and was not aware of any other trainings being stored elsewhere. During an interview of December 1, 2022 registered nurse (RN)-C verified the requested records did not exist and ULP-D and ULP-E's personnel files did not include this information. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01720 SS=F	144G.71 Subd. 4 Resident refusal The assisted living facility must document in the resident's record any refusal for an assessment for medication management by the resident. The facility must discuss with the resident the possible consequences of the resident's refusal and	01720		

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	21118	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDENAS FRIENDSHIP HOUSE	1226 WILDERNESS RUN ROAD EAGAN, MN 55123

(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
01720	Continued From page 17 document the discussion in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to discuss with the resident the possible consequences of the resident's treatment refusal and document the discussion in the resident's record for one of one resident (R3) with records reviewed. 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: R3 began receiving services on January 1, 2022. R3's diagnoses included diabetes and hypertension (HTN). R3's Service Plan included services for medication assistance, vital signs, safety checks, toileting, bathing, dressing, grooming, housekeeping, and activity assistance. On November 30, 2022, the surveyor reviewed the medication administration record (MAR) for R3 and noted daily blood glucose check were not completed for all 30 days in November 2022 as ordered. During an interview, unlicensed personnel (ULP)-D stated that resident always refused this treatment. ULP-D did not provide education to R3 about the refusal of the treatment. In addition,	01720		

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	21118	A. BUILDING: _____ B. WING _____	12/01/2022

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01720	Continued From page 18 ULP-D failed to document the refusals on the handwritten MAR and did not provide a reason for refusal or notify the registered nurse on duty of the refusals. The licensee's Medication & Treatment Record-Documentation & Refusals dated August 1, 2021, indicated the licensee would discuss with the resident the possible consequences of the resident's refusal and document the discussion in the resident medical record. In addition, the licensee would include the reason why a medication or treatment was not completed and any follow up procedures that were provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01720		

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

Type: Full
Date: *11/30/22*
Time: 10:00:00
Report: 1005221217

Food and Beverage Establishment Inspection Report

Location:
Cardenas Friendship House
1226 Wilderness Run Road
Eagan, MN55123
Dakota County, 19

Establishment Info:
ID #: 0038290
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6126701380
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. LOG LEFT WITH OPERATOR.

Comply By: 11/30/22

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

TCS FOODS IN THE KITCHEN REFRIGERATOR WERE AS WARM AS 43 DEGREES F. ADJUST TO A COLDER SETTING.

Comply By: 11/30/22

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

COTTAGE CHEESE WAS NOT DATE-MARKED AND WAS DISCOLORED WITH A BAD ODOR. COTTAGE CHEESE WAS DISCARDED.

Comply By: 11/30/22

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

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

SOME FOODS WERE DATE MARKED, BUT OTHERS SUCH AS MILK AND COTTAGE CHEESE WERE MISSING DATE MARKS. DISCUSSED WHICH FOODS REQUIRE DATE MARKING.

Comply By: 11/30/22

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.

OPERATOR WAS AWARE OF ABOVE REQUIREMENT, BUT COULD NOT FIND TEMPERATURE SENSITIVE STRIPS DURING INSPECTION.

Comply By: 12/07/22

2-100 Supervision

2-102.12AMN

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

OPERATOR HAS THE MN CFPM CERTIFICATE, BUT IS USING IT AT ALL FOUR OF THEIR LOCATIONS. PROVIDE A DEDICATED CFPM AT EACH LOCATION.

Comply By: 12/30/22

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160+ Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/CHOCOLATE MILK
Temperature: 39 Degrees Fahrenheit - Location: MAYTAG FRIDGE, KITCHEN
Violation Issued: No

Process/Item: Cold Hold/SOUR CREAM
Temperature: 43 Degrees Fahrenheit - Location: MAYTAG FRIDGE, KITCHEN
Violation Issued: Yes

Process/Item: Cold Hold/POTATOES
Temperature: 43 Degrees Fahrenheit - Location: MAYTAG FRIDGE, KITCHEN
Violation Issued: Yes

Process/Item: Cold Hold/PIZZA
Temperature: 42 Degrees Fahrenheit - Location: MAYTAG FRIDGE, KITCHEN
Violation Issued: Yes

Type: Full
Date: *11/30/22*
Time: 10:00:00
Report: 1005221217
Cardenas Friendship House

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/SOUP
Temperature: 40 Degrees Fahrenheit - Location: GARAGE FRIDGE
Violation Issued: No

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

INSPECTION COMPLETED WITH OPERATOR AND REVIEWED WITH HRD NURSE EVALUATOR JAMES LARSON.

INSPECTOR LEFT TEMPERATURE INDICATOR STRIPS ON SITE AND OPERATOR LATER SENT INSPECTOR A PICTURE SHOWING THE DISHWASHER PROVIDED A UTENSIL SURFACE TEMPERATURE OF 160+DEGREES .

DISCUSSED:
-BARE HAND CONTACT AND GLOVE USE
-DATE MARKING
-COOK TEMPERATURES
-SANITIZATION
-EMPLOYEE ILLNESS

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE. KITCHEN HAS WOOD LAMINATE FLOORING AND WOOD CABINETS WITH HOLLOW BASE. COUNTERS ARE LAMINATE AND THE CEILING HAS A POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005221217 of 11/30/22.

Certified Food Protection Manager: JESSE J. WOLF

Certification Number: FM105865 Expires: 04/09/24

Signed: _____
JESSE WOLF
OPERATOR

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us