DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 13, 2024

Licensee
Souriyathy Housing With Services
10932 Gettysburg Avenue North
Champlin, MN 55316

RE: Project Number(s) SL36560015

Dear Licensee:

On October 22, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 8, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Electronically Delivered

September 17, 2024

Licensee
Souriyathy Housing with Services
10932 Gettysburg Avenue North
Champlin, MN 55316

RE: Project Number(s) SL36560015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 8, 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 . . ."

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36560	A. BUILDING: _____ B. WING _____	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH CHAMPLIN, MN 55316

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36560015-0 On August 5, 2024, August 8, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; all receiving services under the Assisted Living license. An immediate correction order was identified on August 6, 2024, issued for SL36560015-0, tag identification 0820. On August 8, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at a scope and level of H.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 5, 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		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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0 680	Continued From page 2 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content when the licensee failed to update the EPP to provide temporary shelter accessible by residents who used wheelchairs for mobility. This had the potential to impact all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 680		

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0 680	Continued From page 3 or has the potential to affect a large portion or all the residents). The findings include: R1 admitted on March 2, 2022. R1's nursing assessment dated July 8, 2024, indicated R1 was unable to walk and used a power wheelchair for mobility. R2 admitted on July 8, 2022. R2's nursing assessment dated May 13, 2024, indicated R2 was unable to walk and used a wheelchair for mobility. The licensee's Agreement to Provide Physical Facilities for Temporary Shelter dated January 1, 2024, indicated in the event of emergency, temporary shelter would be provided for the licensee's residents at another assisted living facility owned by the same owner. On August 6, 2024, at 7:37 a.m., the surveyor received an email from owner (O)-C which stated "We have evacuated everyone. The light in the neighborhood is still down." On August 6, 2024, at 7:47 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the power went out to the entire neighborhood, and all the residents had to be evacuated to a hotel. On August 6, 2024, at 9:45 a.m., O-C stated the licensee had residents who used wheelchairs and they realized that the other assisted living owned by the same owner was not wheelchair accessible, so the residents could not receive	0 680		

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0 680	Continued From page 4 temporary shelter there as planned. On August 7, 2024, at 2:30 p.m. O-C stated the power went out in the entire neighborhood, and all the residents had to be evacuated to hotel. O-C acknowledged that their EPP was to evacuate all the residents to another assisted living facility owned by the same owner, but they realized that the facility was not wheelchair accessible, so they had to evacuate to a hotel. The licensee's Disaster Planning and Emergency Preparedness Plan policy dated October 2022, indicated [the facility] will have in place a written plan of action to facilitate the management of client's care and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care and/or services. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story	0 780		

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0 780	Continued From page 5 within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 6, 2024, from 10:45 a.m. to 1:15 p.m., with administrator (A)-D, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. All dwelling units required to have multiple smoke alarms are required to have interconnected	0 780		

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0 780	Continued From page 6 alarms so activation of one alarm activates all alarms within the dwelling unit. During the tour the smoke alarms were tested and A-D, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility and stated they had called a contractor to fix the alarms to be interconnected. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 790		

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0 790	Continued From page 7 safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on August 6, 2024, from 10:45 a.m. to 1:15 p.m., with administrator (A)-D, it was observed that the required fire extinguisher on the main floor and in the basement had a manufacture date of 2022 and no documentation was provided that annual service and monthly inspections were completed for the extinguishers. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to indicate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During the tour on August 6, 2024, at 1:15 p.m., A-D, verified this deficient finding and stated they were going to purchase new fire extinguishers with current year of manufacture. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790		

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0 800	Continued From page 8	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on August 6, 2024, from 10:45 a.m. to 1:154 p.m., with administrator (A)-D, the surveyor made the following observations of facility disrepair: There was a dresser in front of and obstructing the emergency escape and rescue opening on	0 800		

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0 800	Continued From page 9 the side wall of the facility in resident sleeping room 2. Emergency escape and rescue openings are required to be maintained free of obstructions that prevent full and immediate access and use in the event of a fire or similar emergency in accordance with current Minnesota Fire Code. The door latch was missing parts, was difficult to open and needed adjustment on the door leading into resident sleeping room 5 in the basement. Door exit hardware is required to be maintained in working condition as designed in order to provide full and immediate access to the exit in the event of a fire or similar emergency in accordance with current Minnesota Fire Code. There was clothes, furniture and other items covering the floor obstructing the exit path out of resident sleeping room 6 as identified on the evacuation floor plan in the basement next to resident sleeping room 5. The exit path from and within each space shall be maintained free of obstructions that prevent full and immediate use of the exit in the event of a fire or similar emergency in accordance with current Minnesota Fire Code. There was an electrical extension cord routed through a doorway and window opening through the foundation wall to the adjacent basement space and plugged into an outlet in the office next to resident sleeping room 5 in the basement. There were also 2 electrical extension cords providing power to the clothes washing machines in the basement laundry room. Electrical extension cords shall not be routed through doors and windows or provide permanent power in accordance with current Minnesota Fire Code. There was an open electrical junction box with no	0 800		

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0 800	Continued From page 10 cover exposing electrical wires under the stairs in the basement near resident sleeping room 5. The window would not stay up on its own when opened on the front wall facing the street in resident sleeping room 2. Several of the wood window frames had deep deterioration and rot on the exterior from exposure to the weather and water intrusion. There was broken tile on the floor of the shower and missing tile on the curb of the shower in the main floor bathroom. The floor of the shower is required to be maintained and sealed in order to prevent water intrusion into the cavity of the wall or floor structure. The door leading into the main floor bathroom had a 6 inch by 12-inch hole through caused by the movement of wheelchairs in the space. The window handles were missing, and the hardware was broken on all of the windows in resident sleeping room 4 in the upper level of the facility. The window hardware was broken, and the window does not operate as designed in the bathroom in the upper level of the facility next to resident sleeping room 4. The exhaust fan was not working in the bathroom on the main floor. The closet door would not open because it was wedged against the floor in the closet next to the bathroom in the upper level of the facility. The locking hardware on the back door of the garage was installed backwards so the door	0 800		

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0 800	Continued From page 11 would not close and latch. During a facility tour on August 6, 2024, at 1:15 p.m., A-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

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SOURIYATHY HOUSING WITH SERVIC	10932 GETTYSBURG AVENUE NORTH CHAMPLIN, MN 55316

(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
0 810	Continued From page 12 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on August 6, 2024, at 11:00 a.m., the surveyor observed the fire safety and evacuation plan was not located in a central location for all staff and occupants accessibility. The plan was located in a computer file and was not readily available for the occupants use. On August 6, 2024, at 1:15 p.m., owner (O)-C, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810		

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	36560	A. BUILDING: _____ B. WING _____	08/08/2024

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0 810	Continued From page 13 FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP undated, failed to include the following: The number of resident sleeping rooms was not accurate on the evacuation floor plan to identify the location of resident sleeping rooms 4, 5 and 6. The evacuation floor plan did not identify the use of each room in the facility including the room in the basement at the far end of the laundry room and in the storage room to the right of the stairway leading to the laundry room. The evacuation floor plan is required to include accurate location and number of all resident sleeping rooms and identify the use of each room or space in the facility. The resident sleeping room identified on the evacuation floor plan map as resident sleeping room 6 in the basement was identified as resident sleeping room 4 on the door of the room. During an interview on August 6, 2024, at 1:45 p.m., owner (O)-C, and administrator (A)-D stated the evacuation floor plan was not accurate to the location of each resident room and did not identify the use of each room or space in the facility. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing separate documentation from fire drills that the required training was completed. During an interview on August 6, 2024, at 1:50 p.m., O-C, and A-D, stated FSEP training was	0 810		

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0 810	Continued From page 14 provided to employees during the drill, but the training was not documented separately from the evacuation drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=H	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. This had the potential to affect more than a limited number of residents, staff and visitors. 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 pattern scope (when more than a	0 820		

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0 820	Continued From page 15 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On a facility tour on August 6, 2024, from 10:45 a.m. to 1:15 p.m. with administrator (A)-D, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 4, 5 and 6 as identified on the evacuation floor plan map. OCCUPIED RESIDENT SLEEPING ROOMS Resident sleeping room 1, emergency escape and rescue clear window opening measurements are 38 inches wide, 17.5 inches in height, and 665 square inches in openable area. The window was measured with A-D, and survey staff present. The window did not meet the minimum requirements for clear opening height. Resident sleeping room 5, emergency escape and rescue clear window opening measurements are 24 inches wide, 48 inches in height, 1152 square inches in openable area and 53 inches from the floor to the sill (bottom of the clear opening). The window was measured with A-D, and survey staff present. The window did not meet the minimum requirements for clear opening distance from the floor surface below to the bottom of the clear opening sill. Resident sleeping room 6, emergency escape and rescue clear window opening measurements are 20 inches wide, 36 inches in height, 720 square inches in openable area and 54 inches from the floor to the sill (bottom of the clear opening). The window was measured with A-D,	0 820		

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0 820	Continued From page 16 and survey staff present. The window did not meet the minimum requirements for clear opening distance from the floor surface below to the bottom of the clear opening sill. UNOCCUPIED RESIDENT SLEEPING ROOM Resident sleeping room 4, emergency escape and rescue clear window opening measurements are 17.75 inches wide, 48.5 inches in height, and 861 square inches in openable area. The window was measured with A-D, and survey staff present. The window did not meet the minimum requirements for clear opening width. It was explained to A-D, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. Where the windowsill clear opening height is not more than 54 inches a step with the top surface built 48 inches down from the bottom of the windowsill clear opening is permitted. The step shall be at least 18 inches deep (perpendicular from the wall below the window), the full width of the window clear opening and securely fastened in position so it cannot be moved. These deficient conditions were visually verified by A-D, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings.	0 820		

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0 820	Continued From page 17 TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by provider's plan of correction on August 8, 2024, and reviewed by evaluation supervisor on August 8, 2024, however noncompliance remains at a scope and severity of H. DISCARDED SMOKING MATERIALS On the same facility tour on August 6, 2024, from 10:45 a.m. to 1:15 p.m., with administrator (A)-D, it was observed that used cigarette butts were discarded on the speaker and in a coffee cup in resident sleeping room 6, as identified on the floor plan in the basement near resident room 5. There were appropriate containers provided for discarding the used cigarette butts outside on the steps of the front entry and in the garage. DOOR LOCKING On the same facility tour on August 6, 2024, from 10:45 a.m. to 1:15 p.m., with administrator (A)-D, it was observed that there 3 separate locks were installed on the front main required exit door. Required exit doors in this type of building shall be provided with not more than 2 locking devices to allow the door to release to open in accordance with current Minnesota Fire Code. It was also observed the gates in the openings leading out of the two separate basements were provided with barrel bolt slide locks. Locking hardware on gates in the exit path are required to be provided with exit hardware meeting the same requirements as the required exit doors in accordance with current Minnesota Fire Code.	0 820		

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0 820	Continued From page 18 During the tour on August 6, 2024, at 1:15 p.m., A-D, verified the discarded cigarette butts in resident sleeping room 6, and the barrel bolt slide locks on the gates leading out of both basements. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the administration of resident medications was documented by unlicensed personnel (ULP) for one of one employee (ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01750		

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01750	Continued From page 19 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B began employment on April 26, 2022, to provide direct care services to the licensee's residents, including medication administration. On August 7, 2024, at 9:00 a.m., the surveyor observed ULP-B administer medications to R1. ULP-B removed R1's monthly medication box from the locked medication closet. ULP-B opened R4's medication box and revealed boxes labeled one through thirty-one. ULP-B removed box number seven and the box contained three openings indicating morning, noon, and night medications. ULP-B opened the opening labeled for morning and placed eight tablets into a medication cup and administered them to R4. ULP-B failed to reference or compare the medication given to R4's electronic medication administration record (EMAR) prior to administration. On August 6, 2024, at 9:45 a.m., ULP-B stated he was supposed to verify medications to the EMAR before administering medications. ULP-B's employee record indicated they had been trained on medication administration and passed a competency evaluation on April 20, 2023. On August 7, 2024, at 10:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated all staff had been trained for medication administration, and they were instructed to verify the EMAR before	01750		

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01750	Continued From page 20 administering medications. LALD/RN-A stated they would have to retrain all the staff. The licensee's undated Training Unlicensed Personnel for Medication, Treatment and Therapy Administration policy indicated before the RN delegates the task of medication administration the RN will instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	01770		

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01770	Continued From page 21 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's Service Plan dated March 2, 2023, included services of medication administration, hands on assistance with transfers, behavior monitoring, bathing assistance, transfer assistance, meal assistance, laundry, and assistance with dressing. On August 7, 2024, at 9:00 a.m., the surveyor observed ULP-B administer medications to R1 from a medication set-up box. In addition, the surveyor observed the medication storage closet and found all resident medications were set up in medication set-up boxes. R1's record lacked documentation of medication set-up by the registered nurse (RN). On August 7, 2024, at 10:45 a.m., licensed assisted living director/RN (LALD/RN)-A stated he sets all resident medications up in medication set-up boxes and was aware of the documentation requirements for medication set up, but no documentation was provided to the surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 22 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards with side rails for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 On August 5, 2024, at 11:00 a.m., during tutor, the surveyor observed R1 was sitting in his wheelchair and the surveyor noted the hospital bed to have side rails in the upright position on both sides of the bed. R1 stated he used the side rails to get in and out of bed. R1 stated education regarding side rails was provided to him by the licensee. R1's Service Plan dated March 2, 2023, included services of medication administration, hands on assistance with transfers, behavior monitoring, bathing assistance, transfer assistance, meal	02310		

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02310	Continued From page 23 assistance, laundry, and assistance with dressing. R2's Nursing Assessment with effective date July 8, 2024, indicated side rails were in use. R1's medical record lacked specific measurements of the zones of entrapment. R2 On August 5, 2024, at 11:00 a.m., during tour, the surveyor observed R2 was lying in a hospital bed with half side rails on both sides of the bed. R2's Service Plan dated July 8, 2022, included services of medication administration, hands on assistance with transfers, behavior monitoring, positioning, bathing assistance, transfer assistance, meal assistance, laundry, and assistance with dressing. R2's Nursing Assessment with effective date May 13, 2024, indicated side rails were in use. R2's medical record lacked specific measurements of the zones of entrapment. On August 6, 2024, at 2:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A verified R1 and R2's assessments did not include measurements of zones and the assessments were not thorough. LALD/RN-A stated it must have been an oversite as it was required for a side rail assessment which included measurements of the zones to be completed for R1 and R2's side rails. The March 10, 2006, Food and Drug Administration (FDA) Side Rail Entrapment Zones and Dimensional Recommendations indicated to	02310		

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02310	Continued From page 24 reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." "Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct	02310		

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02310	Continued From page 25 installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/05/24*
Time: 11:00:00
Report: 1039241236

Food and Beverage Establishment Inspection Report

Location:
Souriyathy Housing With Servic
10932 Gettysburg Avenue North
Champlin, MN55316
Hennepin County, 27

Establishment Info:
ID #: 0038334
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123681236
ID #:

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

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

SHELL EGGS IN CARDBOARD BOX HELD IN COOLER ABOVE PRODUCE. COMPLY WITH ABOVE. GUIDANCE DOCUMENT ON SEPARATION REQUIREMENTS SENT WITH REPORT.

Comply By: 08/05/24

7-200 Toxic Supplies and Applications

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

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

CHLORINE BLEACH SOLUTION IN SPRAY BOTTLE USED IN KITCHEN MEASURES >>200 PPM (LABELED AS >1%). ESTABLISHMENT WILL NO LONGER USE. USE 50 TO 200 PPM CHLORINE FOR SANITIZING FOOD CONTACT SURFACES. PREPARE BY MIXING 1 TABLESPOON BLEACH WITH 1 GALLON OF WATER.

Corrected on Site

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.

COOKED FOOD PROVIDED BY LUNCH CATERED HELD IN REFRIGERATOR WITHOUT DATE

MARK. DATE MARK THIS FOOD.
Comply By: 08/05/24

4-300 Equipment Numbers and Capacities

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

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

NO TEST STRIPS FOR MEASURING CHLORINE BLEACH ARE ON-HAND. COMPLY WITH ABOVE. CHLORINE TEST STRIPS GUIDANCE EMAILED WITH THIS REPORT.

Comply By: 08/05/24

6-300 Physical Facility Numbers and Capacities

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

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

NO PAPER TOWELS PRESENT AT SINK. STAFF ADDED DISPOSABLE NAPKINS. MAINTAIN SUPPLY OF DISPOSABLE TOWELS AT SINK AT ALL TIMES TO COMPLY WITH ABOVE.

Corrected on Site

4-100 Equipment Construction Materials

4-101.17

MN Rule 4626.0490 Discontinue using wood and wood wicker as a food contact surface.

LARGE, WORN WOODEN CUTTING BOARD USED IN KITCHEN. DISCARD CUTTING BOARD AND USE NON-ABSORBENT ALTERNATIVE.

Comply By: 08/05/24

Surface and Equipment Sanitizers

Utensil Surface Temp: = at >160 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: COOKED RICE
Temperature: 182 Degrees Fahrenheit - Location: HOT HOLD IN WARMER/COOKER
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COLD HOLD IN REFRIGERATOR
Violation Issued: No

Process/Item: FREEZER IN GARAGE
Temperature: Degrees Fahrenheit - Location: MEATS FROZEN SOLID
Violation Issued: No

Type: Full
Date: *08/05/24*
Time: 11:00:00
Report: 1039241236
Souriyathy Housing With Servic

Food and Beverage Establishment Inspection Report

Process/Item: FREEZER SIDE OF REFRIG.
Temperature: Degrees Fahrenheit - Location: FROZEN
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH nurse evaluator Safia Hassan.

The kitchen is of residential build and should serve food for same-day service only. No undercooked eggs or meats should be served to residents. Guidance on service to highly susceptible population sent with this report.

Per establishment operator, some meals are prepared by staff in commercial kitchens at the locations listed below and delivered for at meal time. Hot meals must be received at 135 degrees F or above, cold TCS food at 41 degrees F or below.
- 3001 Broadway St. NE Box #7, Minneapolis, Mn. 55413
- PhoEVER; 4022 Central Ave. NE, Columbia Height, Mn. 55421

The kitchen has wood cabinets with hollow base, wood floor, textured/painted walls with popcorn ceiling and faux-stone countertops with decorative tile backsplash. These kitchen finishes and surfaces are clean and well maintained.

The kitchen refrigerator/freezer are of residential grade.

There is an additional freezer in garage.

A 2-compartment sink is present in kitchen. 1 compartment is designated for handwashing only.

A residential dishwashing machine is present in the kitchen. Per color change test strip, the dishwashing machine achieves a utensil surface temperature of >160 degrees F.

A supply of single-use gloves is present in kitchen. A thin-probe food thermometer is present in kitchen.

Discussed the following with the person-in-charge: minimum cook temps for animal proteins, food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing.

Type: Full
Date: *08/05/24*
Time: 11:00:00
Report: 1039241236
Souriyathy Housing With Servic

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 Minnesota Department of Health inspection report number 1039241236 of 08/05/24.

Certified Food Protection Manager: Hassan Kamara

Certification Number: FM121946 Expires: 03/19/27

Inspection report reviewed with person in charge and emailed.

Signed:_____
Phinhsaykeo Souriyathay
person-in-charge

Signed:_____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us