Electronically Delivered

October 27, 2022

Administrator
Adna Homes LLC
7733 Abbott Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL35731015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 23, 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.

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 . . ."

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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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, no immediate fines are assessed.

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

INFORMAL CONFERENCE REQUESTED

Although no immediate fines are assessed related to the findings of this evaluation, your facility was noted to be operating with mixed occupancy. Per the requirements of assisted living licensure noted in Minn. Stat. Chpt. 144G, an assisted living facility licensee must license the entire structure, and all residents in the facility must have a current assisted living contract.

Please contact me at the phone number or email address below, on or before Wednesday, November 9, 2022, to schedule an informal conference to discuss this issue and options to correct the noncompliance

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,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35731	A. BUILDING: _____ B. WING _____	08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADNA HOMES LLC	**7733 ABBOTT AVENUE NORTH BROOKLYN PARK, MN 55443**

(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: SL#35731015 On August 22, 2022, through August 23, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents receiving services under the provider's Assisted Living license.	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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 according to the Minnesota Food Code. This had the potential to affect all three current residents of the licensee. 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: Please refer to the additional documentation	0 480		

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0 480	Continued From page 2 included in the Food and Beverage Establishment Inspection Reports, dated August 23, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) 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: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all three residents who received services.	0 485		

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0 485	Continued From page 3 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 22, 2022, at approximately 9:35 a.m., the surveyor observed the menu posted on the communication board was not two weeks in advance. On August 22, 2022, at approximately 10:55 a.m., licensed assisted living director (LALD)-B acknowledged the week in advance menu was not posted as required and stated the licensee was not aware of the menu requirement. The licensee's Food Service policy dated July 31, 2021, indicated the licensee will use a person-centered approach to assure that residents receive healthy, nutritious meals and snacks. The policy indicated menus are prepared one week in advance and made available to all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 4 information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure with the required content. This had the potential to affect the licensee's three current 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: During a facility tour on August 22, 2022, at approximately 10:20 a.m., the surveyor observed the common areas lacked the required posting for grievance procedure and information related to reporting suspected maltreatment to include: - the name, telephone number, and e-mail	0 550		

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0 550	Continued From page 5 contact information for the individuals who are responsible for handling resident grievances - contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities - information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. On August 22, 2022, at approximately 10:25 a.m., licensed assisted living director (LALD)-B acknowledged the licensee's grievance procedure was not posted. In addition, LALD-B stated the information was included in the contract and the assisted living bill of rights, but there was no posted reference to the same. The licensee's undated Posting in Public area policy indicated all missing information will be posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630		

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0 630	Continued From page 6 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for one of one resident (R1) with record 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted to the licensee October 31, 2021, with diagnoses including traumatic brain injury (TBI), attention deficit hyperactivity disorder (ADHD), antisocial personality disorder, severe anxiety, and bipolar disorder. R1's Clinical Update Assessment dated July 31, 2022, indicated R1 has the following vulnerabilities: fall risk, housekeeping, laundry, shopping, arranging transportation, partial blindness, physical help in emergency, risk to be abused, risk to abuse other vulnerable adults, history of suicide thoughts, risk of abusing self, physically aggressive, verbally aggressive, resistive to cares, and anxiety. R1's IAPP lacked statements of the specific measures to be taken	0 630		

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0 630	Continued From page 7 to minimize the risk of abuse to R1 and other vulnerable adults. On August 23, 2022, administrator (A)-D acknowledged R1's IAPP lacked statements of the specific measures to be taken to minimize the risk of abuse. In addition, A-D stated registered nurse (RN)-A will update the IAPP. The licensee's Vulnerable Adult policy dated July 31, 2021, indicated the licensee will assess residents to determine the risk of abuse or neglect and develop a specific plan to minimize the risk to that resident. The policy lacked verbiage to include interventions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced	0 640		

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0 640	Continued From page 8 by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all three 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 August 22, 2022, at approximately 10:10 a.m., the surveyor observed the facility's main entry area and common areas lacked the required postings to include: - posting of 911 emergency number in common areas and near telephones provided by the assisted living facility - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On August 22, 2022, at approximately 10:15 a.m., licensed assisted living director (LALD)-B acknowledged the required content noted above had not been posted. In addition, LALD-B stated the licensee will post the 911 and MAARC numbers immediately.	0 640		

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0 640	Continued From page 9 The licensee's undated Posting in Public area policy indicated all missing information will be posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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 the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to maintain a tuberculosis (TB) infection control program based on guidelines by the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH) and ensure TB health screenings were completed as required for	0 660		

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0 660	Continued From page 10 one of two employees (unlicensed personnel (ULP)-C) with employee health 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated October 22, 2021, indicated the licensee was a low risk setting for TB transmission. ULP-C was hired on November 8, 2021, and provided direct cares for residents of the licensee. ULP-C's employee record included a TB history and symptom screening form completed November 29, 2021, a TB skin test completed June 29, 2020, indicating ULP-C was negative for TB, and a chest x-ray completed August 23, 2022, indicating ULP-C had a negative chest impression for TB. ULP-C's employee record lacked a second step TB skin test. In addition, ULP-C's first step TB skin test was dated over 90 days before hire date. On August 23, 2022, at approximately 11:20 a.m., administrator (A)-D acknowledged the findings and stated the licensee was not aware of the anomaly but will take necessary steps to be compliant with TB requirement.	0 660		

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0 660	Continued From page 11 The licensee's Tuberculosis Screening/Prevention policy dated July 31, 2021, indicated the licensee will observe the recommended precautions related to TB prevention as identified by the CDC and MDH. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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	0 680		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADNA HOMES LLC	7733 ABBOTT AVENUE NORTH BROOKLYN PARK, MN 55443

(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
0 680	Continued From page 12 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 with all the required content as defined in Appendix Z. This had the potential to affect the licensee's residents, staff, and guests. 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 August 22, 2022, at approximately 10:40 a.m., the surveyor requested to review the licensee's emergency preparedness plan (EP), and a three ringed bidder that contained the licensee's EP was provided. The licensee's EP lacked the following content: - Development of EP policies and procedures; - Subsistence needs for staff and patients; - Procedures for tracking of staff and patients; - Policies and procedures including evacuation; - Policies and procedures for sheltering; - Policies and procedures for medical documents; - Policies and procedures for volunteers; - Roles under a waiver declared by Secretary; - Emergency officials contact information; - Primary/alternate means for communication;	0 680		

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0 680	Continued From page 13 - Methods for sharing information; - LTC family notifications; - Emergency prep training program; - Emergency prep testing requirements; - LTC emergency power (typically engineering); and - Integrated health systems On August 22, 2022, at 10:48 a.m., administrator (A)-D acknowledged the licensee's EP lacked the content above. A-D stated the licensee's management staff will update the EP to include the missing content. The licensee's Emergency Preparedness policy dated July 31, 2021, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of emergency or disaster that disrupts services. The policy did not identify the required content to include in an emergency preparedness plan. No additional information was 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;	0 780		

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0 780	Continued From page 14 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story 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 a working smoke alarm in the upstairs hallway and the interconnection of required smoke alarms in the home. This has the potential to directly affect all resident, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 23, 2022, approximately from 2:15 p.m. to 3:30 p.m., survey staff toured the home with the administrator (A)-D. During the tour,	0 780		

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0 780	Continued From page 15 survey staff observed the following: 1) The home consisted of multiple brands of smoke alarms. When the A-D tested the smoke alarm located in resident bedroom #2 and other smoke alarms located throughout the home, all alarms sounded local. The A-D and survey staff agreed that the smoke alarms were not interconnected. Survey staff explained to the A-D that the law requires when one smoke alarm is activated, all smoke alarms must sound throughout the home. The A-D commented that she thought they had taken care of the interconnection of the home ' s smoke alarms already. 2) The combination smoke and carbon monoxide alarm in the upstairs hallway next to the resident bedrooms failed to sound when the A-D had asked the licensed assisted living director (LALD)-B to test the alarm. The LALD-B removed the alarm for further investigation and the entire unit came off easily including the wire. It was evident that the combination alarm was not wired into the home ' s hardwire system as the wires were hanging loose on the combination alarm that was removed. On August 23, 2022, at approximately 4:05 p.m., during the exit interview, the A-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 16 (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 physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings are: On August 23, 2022, approximately from 2:15 p.m. to 3:30 p.m., survey staff toured the home with the administrator (A)-D. During the tour, survey staff observed the following: 1) The shower rod and the curtain in the bathroom of resident bedroom #1 were observed on the floor between the toilet and the shower. In addition, the light switch in the bathroom was missing a switch cover for proper operation as	0 800		

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0 800	Continued From page 17 survey staff was not able to turn on the light without assistance from the A-D. 2) In the mechanical room, survey staff observed the water softener backwash discharge line was submerged into the floor drain located under the laundry sink which poses potential cross-connection and contamination of the drinking water supply system. The backwash line must be secured above the floor and discharged above the flood rim of the laundry sink or above the floor drain by means of a proper airgap. 3) The A-D opened the sliding window in resident bedroom #3 with some level of difficulty. Survey staff explained to the A-D to ensure all egress windows must be maintained for easy opening and operation for immediate use during a fire or similar emergency. 4) The glass window on the front entrance door was observed to be shattered and had duct tape on the door where the glass was shattered and missing. The A-D explained that it was already being taken care of. On August 23, 2022, at approximately 4:05 p.m., during the exit interview, the A-D acknowledged the above findings. No Further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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	0 810		

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0 810	Continued From page 18 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee lacked fire protection procedures for residents and employee training on the home ' s fire safety and evacuation plan. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors.	0 810		

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0 810	Continued From page 19 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 23, 2022, at approximately 3:30 p.m., survey staff received the home ' s fire safety and evacuation documentation and related documentation from the administrator (A)-D. The review of the documentation indicated the following findings: 1) The plan documentation lacked fire protection procedures for residents. 2) Documentation review showed the licensee lacked record of employee training on the fire safety and evacuation plan for the home beyond Edu-care online training. The minimum required employee training is upon hire and twice a year. Survey staff explained that the fire safety and evacuation training was in addition to the annual required emergency preparedness plan training. On August 23, 2022, at approximately 4:05 p.m., during the exit interview, the A-D acknowledged the above findings. No Further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		

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0 970	Continued From page 20	0 970		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's undated assisted living contract included two clauses that indicated the resident would waive the licensee's liability for health, safety, or personal property. - Page 12 under miscellaneous provisions, section one of the contract indicated the provider was not liable to the resident for any injury, death	0 970		

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0 970	Continued From page 21 or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurred because of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests. - Page 14, section Indemnification of the contract indicated the licensee shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold license harmless from any claims or damages unless caused solely by negligence of licensee. On August 22, 2022, at approximately 11:45 a.m., administrator (A)-D acknowledged the assisted living contract required residents to waive the licensee's liability for health, safety, or personal property. A-D confirmed the same assisted living contract was used for all residents of the licensee. The licensee's undated Contract policy indicated the licensee has a commitment to provide a safe environment and empower residents to achieve their goals. The policy lacked verbiage to include contract content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890		

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01890	Continued From page 22 by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information. In addition, the licensee failed to dispose of expired medication for one of three residents (R1) 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 23, 2022, at approximately 8:40 a.m., licensed assisted living director/unlicensed personnel (LALD/ULP)-B prepared and administered insulin to R1. On August 23, 2022, at approximately 9:00 a.m., the surveyor observed the contents of R1's medication storage area and noted the following: Unlabeled/time sensitive medications: - melatonin 3 milligram (mg) - ibuprofen 200 mg tablet take one to two tablets orally every 4 hours as needed - Nature Made D3 25 microgram (mcg) tablet	01890		

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01890	Continued From page 23 take one tablet daily - Biotene Dry Mouth Moisturizing Spray 1.5 fluid ounce (fl. oz.) Expired medications: - triamcinolone acetamide cream 0.5% Apply a thin film to affected areas two to four times a day expired March 9, 2022 - glucose tablet 4 mg expired March 9, 2022 - nicotine 4 mg chewing gum expired February 13, 2022 - fluticasone nasal spray 50 mcg two sprays in each nostril once a day expired April 2022 On August 23, 2022, at approximately 10:45 a.m., administrator (A)-D acknowledged the findings and stated the licensee's registered nurse completes medication carts audit monthly but will need to audit storage areas. The licensee's Medication Orders policy dated July 31, 2021, indicated the licensee will administer medications as prescribed by the authorized prescriber in accordance with all the rights. The policy lacked verbiage to include labeling and expired medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	01940		

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01940	Continued From page 24 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan to include all the required content for one of three residents (R1) 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	01940		

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01940	Continued From page 25 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on October 31, 2021, with diagnoses to include type one diabetes, traumatic brain injury (TBI), and bipolar disorder. R1's Blood Glucose record dated August 2022, indicated R1 had blood glucose checks four time a day. R1's individual treatment management plan lacked the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received. On August 22, 2022, at approximately 12:10 p.m., registered nurse (RN)-A acknowledged R1's record lacked the above required content. RN-A stated he will complete the individual treatment management plan with the required content. The licensee's Treatment and Therapy Management policy dated July 31, 2021, indicated the licensee will use treatment and	01940		

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01940	Continued From page 26 therapy protocols consistent with current evidence-based practice standards and guidelines, to include all missing content above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *08/23/22*
Time: 15:27:46
Report: 1018221111

Food and Beverage Establishment Inspection Report

Location:
Adna Homes Llc
7733 Abbott Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0039316
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632086626
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.

RAW EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE REFRIGERATOR. CORRECTED ON SITE.

Corrected on Site

Food and Equipment Temperatures

Process/Item: Cold Holding/ EGGS
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

FIRM DOES ONLY SAME DAY SERVICE OF FOODS.

PHYSICAL FACILITIES WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION. THE KITCHEN IS A RESIDENTIAL KITCHEN WITH RESIDENTIAL EQUIPMENT.

DISCUSSED PEST CONTROL AND ILLNESS POLICIES WITH THE MANAGER.

Food and Beverage Establishment Inspection Report

DISHWASHER WAS OBSERVED TO HAVE A SANITIZING FUNCTION AVAILABLE FOR DISHES.

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 1018221111 of 08/23/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
SUE SHERIF
MANAGER

Signed:_____
Inspector Number 1018

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