DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

August 8, 2022

Administrator
Midwest Residential, Inc.
10449 Johnson Avenue South
Bloomington, MN 55437

RE: Project Number(s) SL36984015

Dear Administrator:

On August 4, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the April 28, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

July 18, 2022

Administrator
Midwest Residential, Inc.
10449 Johnson Avenue South
Bloomington, MN 55437

RE: Project Number(s) SL36984015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on April 28, 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, the following fines are assessed pursuant to this evaluation:

**St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000**

**The total amount you are assessed is $3,000**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

**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: | 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

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36984 | A. BUILDING: _____ B. WING _____ | 04/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIDWEST RESIDENTIAL INC | 10449 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437 |

| (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 |
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| 0 000 | Initial Comments<br><br>Initial comments<br>*****ATTENTION******<br><br>ASSISTED LIVING LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL36984015<br><br>On April 26, 2022, through April 28, 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 six (6) residents, all of whom received services under the provider's Assisted Living license.<br><br>On April 27, 2022, an immediate correction order was issued at 2310. The immediacy of the correction order, tag identification 2310 was removed April 27, 2022, at approximately 4:05 p.m. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |

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| 0 120 SS=C | 144G.11 APPLICABILITY OF OTHER LAWS<br><br>Assisted living facilities:<br>(1) are subject to and must comply with chapter 504B;<br>(2) must comply with section?325F.72; and<br>(3) are not required to obtain a lodging license under chapter 157 and related rules.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure an assisted living advertising dementia care, had an assisted living dementia care license in place. This had the potential to affect all six (6) residents.<br><br>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 potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The facility was licensed as an Assisted Living facility.<br><br>Review of the licensee's website revealed advertisement to provide services for dementia care, including Alzheimer's disease.<br><br>On April 28, 2022, at 12:00 p.m. the administrator (A)-A stated the licensee provided services to residents with a dementia diagnosis, and verified the licensee advertised for dementia care. A-A verified the licensee lacked a policy on | 0 120 | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is | |

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| 0 120 | Continued From page 2<br>advertisement of services provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 120 | used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(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:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all six (6) residents residing at the facility.<br><br>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 | 0 480 | | |

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| 0 480 | Continued From page 3<br>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).<br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 26, 2022, for the specific Minnesota Food Code deficiencies.<br><br>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<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(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:<br><br>(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;<br><br>(C) the facility cannot require a resident to include and pay for meals in their contract; | 0 485 | | |

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| 0 485 | Continued From page 4<br><br>This MN Requirement is not met as evidenced by:<br>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 six (6) residents.<br><br>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).<br><br>During the entrance conference on April 26, 2022, at 10:15 a.m. the administrator (A)-A and director (D)-B stated the licensee provided three meals daily and snacks as offered or requested.<br><br>During a tour of the licensed facility on April 26, 2022, at 10:45 a.m. a single-day menu dated March 14, 2022, was observed attached to the refrigerator in the main floor kitchen. Although a category for lunch and dinner was provided, a breakfast category was not included on the menu. No other menu was observed posted or in the possession of a resident.<br><br>On April 26, 2022, at 11:50 a.m. D-B provided The Midwest Community Menu Week One and Week Two. The menus were identical and neither provided an alternative meal, a date, or a time. D-B stated the cycle menus did not work in the past. D-B stated, "We just ask. They get what they want." | 0 485 | | |

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| 0 485 | Continued From page 5<br><br>On April 27, 2022, at 8:30 a.m. a resident (R)-1 stated she was never provided a menu, "only sometimes" she was told what the meal included and was not given a choice or provided with an alternate meal even when she had requested one.<br><br>On April 27, 2022, at 8:50 a.m. R2 explained she was never given a menu or observed a posted menu. R2 stated, "They don't tell us what we are having or give us a choice. I need to ask for something else if I don't like what we are having. Sometimes I get it."<br><br>During an interview on April 28, 2022, at 12:00 p.m. A-A stated the licensee was expected to have menus posted, or in the possession of the resident, at least one week in advance and an alternative meal should be included on the menu.<br><br>Licensee's Food Service policy dated August 1, 2021, indicated:<br>-food would be served according to the posted menu<br>-menus would be prepared at least one week in advance and be made available to all residents<br>-meal substitutions would be of similar nutritional value if a resident refused that food which was served<br>-residents must be informed in advance of menu changes<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |

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| 0 490 | Continued From page 6 | 0 490 | | |
| 0 490 SS=F | 144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements<br><br>(ii) weekly housekeeping;<br>(iii) weekly laundry service;<br>(iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance;<br>(v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance;<br>(vi) provide culturally sensitive programs; and<br>(vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all six (6) residents of the facility.<br><br>This practice resulted in a level two violation (a | 0 490 | | |

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| 0 490 | Continued From page 7<br>violation that did not harm a resident's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>The licensee lacked a daily program of activities as required.<br><br>On April 26, 2022, at 10:45 a.m., during a tour of the licensee, the surveyor did not observe a posted activity calendar throughout the common areas or in the residents' private room.<br><br>Observations on April 26, 27, and 28, 2022, revealed the licensee did not provide or offer activities to a group or to an individual resident that were planned or unplanned. Some residents remained in their room most or all day and some came out for meals or medication administration.<br><br>On April 27, 2022, at 8:40 a.m., a resident (R)1 stated she was not provided an activity calendar nor was she aware of group or individual activites provided by the licensee.<br><br>On April 27, 2022, at 9:05 a.m., R2 explained she was not given an activity calendar. R2 further explained that although there were activities, such as music or shopping trips, she was not informed in advance.<br><br>On April 28, 2022 at 9:45 a.m., the director (D)-B stated an activity calender was not posted in a common area or given to residents of the facility. | 0 490 | | |

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| 0 490 | Continued From page 8<br><br>D-B confirmed, although the licensee provided internet, television, board-games, shopping trips and diamond art, an activity program had not been developed with the required content<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 490 | | |
| 0 650 SS=D | 144G.42 Subd. 8 Employee records<br><br>(a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:<br>(1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;<br>(2) records of orientation, required annual training and infection control training, and competency evaluations;<br>(3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;<br>(4) documentation of annual performance reviews that identify areas of improvement needed and training needs;<br>(5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and<br>(6) documentation of the background study as required under section 144.057.<br>(b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed | 0 650 | | |

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| 0 650 | Continued From page 9<br>by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the employee record contained the required content for one of one unlicensed personnel (ULP)-D with employee records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-D's employee record lacked a review of the provider's policies and procedures and annual performance reviews.<br><br>ULP-D was hired on April 3, 2018, to provide assisted living services under the Comprehensive home care license and converted to an Assisted Living Facility (ALF) license on August 1, 2021.<br><br>On April 26, 27, and 28, 2022, ULP-D was observed providing cares and services to include medication management and meal preparation.<br><br>On April 28, 2022, at 9:55 a.m. the administrator (A)-A verified ULP-D's employee record did not | 0 650 | | |

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| 0 650 | Continued From page 10<br>contain evidence of orientation to licensee's policies and procedures or a current annual performance review. A-A further explained she would expect these documents to be in the employee's record if they were completed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 650 | | |
| 0 660 SS=D | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(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.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure history and symptoms | 0 660 | | |

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| 0 660 | Continued From page 11<br>screening and screening for active TB (either a two-step tuberculin skin test [TST] or blood test) were completed and documented for one of one employee (unlicensed personnel (ULP)-D) with employee record reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-D's employee record lacked evidence of a current health history and symptom screening, including completion of a two-step TST or other evidence of TB screening, such as a blood test upon hire date.<br><br>ULP-D's employee record had a TB history and symptom screen completed on August 5, 2016 and a baseline screening (TST second-step) dated September 6, 2016. ULP-D's employee record showed a start date of April 3, 2018.<br><br>On April 26, 2022, at 1:30 p.m. the administrator (A)-A confirmed ULP-D did not complete the required TB history and symptom screening or a TST or blood test, as required upon hire and the licensee did not have a program to ensure this practice. A-A stated the licensee was not aware employees were required to have an annual TB history and symptom screen and a TST or blood test, upon hire. A-A further stated she thought employee screening and testing for TB were | 0 660 | | |

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| 0 660 | Continued From page 12<br>required only one time. A-A verified this was true for all employees in the facility.<br><br>The licensee's Tuberculosis Prevention Control Plan, revised August 16, 2021, included:<br>- new staff will be screened for active signs of TB using the baseline TB screening tool for HCW's (healthcare workers)<br>-new staff will have an IGRA blood test or two-step Mantoux or X-ray conducted with results documented on the Baseline TB Screening Tool for HCWs<br>-no staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented, or a negative test result is received and documented<br>-staff TB screening results will be kept will be kept in each employee's medical file<br>-staff should be screened for signs and symptoms on an annual basis<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record."<br><br>No further information was provided. | 0 660 | | |

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| 0 660 | Continued From page 13<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed provide smoke alarms that are interconnected throughout the facility. This deficient condition had the ability to affect all staff and residents. | 0 780 | | |

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| 0 780 | Continued From page 14<br><br>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).<br><br>Findings include:<br><br>On a facility tour on April 26, 2022, at approximately 11:20 a.m. with Administrator (A)-F, it was observed that the smoke alarms throughout the entire facility were not interconnected so that the actuation of one would cause all alarms to operate. An interview with A-F verified this deficient finding at the time of discovery.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the physical environment, | 0 800 | | |

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| 0 800 | Continued From page 15<br><br>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. This deficient condition had the ability to affect a limited number of staff and residents.<br><br>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).<br><br>Findings include:<br><br>On a facility tour on April 26, 2022, at approximately 11:20 a.m. with Administrator (A)-F, it was observed that the fire separation wall between the between the garage and the attic to the home had a large hole in the sheetrock. A fire separation wall is required to be intact to protect the occupants from a possible fire in a garage due to being a more hazardous area. An interview with A-F verified this deficient finding at the time of discovery.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping | 0 810 | | |

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| 0 810 | Continued From page 16<br>rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on a record review and interview, the licensee failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors.<br><br>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 | 0 810 | | |

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| 0 810 | Continued From page 17 | 0 810 | | |

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).

Findings include:

A record review and interview were conducted on April 20, 2022, at approximately 12:50 p.m. with Administrator (A)-F and Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.

Record review of the available documentation indicated that the fire safety and evacuation plan did not have fire protection procedures or actions to be taken by residents in a fire or similar emergency. An interview with LALD-A indicated that the licensee had these provisions in the fire safety and evacuation plan but were unable to provide these provisions of the plan for review.

Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. An interview with LALD-A indicated that the licensee had these provisions in the fire safety and evacuation plan but were unable to provide these provisions of the plan for review.

Record review of the available documentation indicated that fire safety and evacuation plan was not readily available at all times in the facility. An initial request for the fire safety and evacuation

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| 0 810 | Continued From page 18<br>plan details were requested upon the entrance interview with A-F but were not able to be located or provided at that time. Additional requests were made at the exit interview, but A-F and LALD-A were not able to locate all the requested provisions.<br><br>Record review of the available documentation indicated that that the licensee did not have documentation indicating that the last recorded drill provided by the licensee was dated September 5, 2021. An interview with A-F and LALD-A indicated that the licensee had not conducted any additional drills to meet the minimum every other month requirement in statute.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>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 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:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that | 01940 | | |

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| 01940 | Continued From page 19<br>will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R2) receiving treatments with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The Findings Include:<br><br>R2's provider orders indicated R2 recieved an order for oxygen on March 10, 2022.<br><br>R2's service plan dated March 10, 2022, | 01940 | | |

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| 01940 | Continued From page 20<br>indicated R2 was receiving oxygen..<br><br>R2's Medication Administration Record for April 2022, indicated staff was to take and record oxygen saturation levels every two hours during the first and second shifts daily (10:00 a.m through 10:00 p.m.) however, the record lacked specific parameters for oxygen saturation levels, when and how to apply oxygen for R2 and when and who to notify when the oxygen saturation level was not within the parameter guidelines.<br><br>On April 27, 2022, at 10:35 a.m. during a telephone conversation, the registered nurse (RN)-B, verfied R2's treatment management plan lacked specific parameters for oxygen saturation levels and when to apply oxygen for R2. RN-B stated she "just now"called R2's primary doctor for guidelines regarding oxygen saturation levels and oxygen application. RN-B verified the specific parameters or guidelines were not evident in R2's medical record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 02310 SS=I | 144G.91 Subd. 4 Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record | 02310 | | |

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| 02310 | Continued From page 21 | 02310 | | |

review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for three of three residents (R1, R2, R3) who utilized bed rails with records reviewed. This resulted in an immediate correction order on April 27, 2022, at 10:07 a.m.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

R1, R2, and R3's bedrails assessment lacked the required measurements of the zones of entrapment; in addition, R2 and R3 lacked evidence they were given risk versus benefits for side rail use.

R1 had diagnoses to include hemiplegia and hemiparesis with left non-dominant side, peripheral vertigo and acute respiratory failure, and received services to include medication administration, dressing, grooming and mobility.

R2 had diagnoses to include rheumatoid arthritis and received services to include medication administration, dressing and grooming, and toileting.

R3 had diagnoses to include pain and received services to include medication administration, dressing, grooming, toileting, mobility and

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 02310 | Continued From page 22<br>behavior.<br><br>On April 26, 2022, at 11:35 a.m. during the tour of the licensee, the following was observed:<br>-R1 was observed in bed with bilateral half rails in the raised position near the head of the bed. R1's Midwest Residential Side-Rail Use Assessment Form, dated September 8, 2020, included the risk and benefits of bedrail use, however lacked measurement of bedrails.<br>-R2 was observed in bed with bilateral half rails with the left bedrail in the raised position near the head of the bed. The siderail assessment dated January 6, 2022, lacked the risk and benefits of bedrail use and measurements of the bedrails.<br>-R3's bed was observed to have two half rails near the head of the bed. The siderail assessment dated August 17, 2021, lacked the risk and benefits of bedrail use and measurements of the bedrails.<br><br>On April 27, 2022, at 9:15 a.m. registered nurse (RN)-B stated bedrail measurements were not completed because "we trust the company who makes the mattresses."<br><br>On April 27, 2022, at 9:26 a.m. administrator- (A) stated the licensee did not measure bedrails for safety because they were hospital beds. The administrator verified the licensee did not use the The Food and Drug Administration (FDA) "A Guide to Bed Safety," for guidance.<br><br>The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36984 | A. BUILDING: _____ B. WING _____ | 04/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MIDWEST RESIDENTIAL INC | 10449 JOHNSON AVENUE SOUTH BLOOMINGTON, MN 55437 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 23<br>memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br><br>The licensee's Policy for bedrails dated August 1, 2021, verified the licensee would be permitted with side rails that comply with the 2006 FDA dimensional guidance to reduce entrapments.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate<br><br>The immediacy of the correction order, tag identification 2310 was removed April 27, 2022, at approximately 4:05 p.m. Scope and level remain unchanged. | 02310 | | |

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *04/26/22*
Time: 15:22:19
Report: 7963221048

# Food and Beverage Establishment Inspection Report



**Location:**
Midwest Residential Inc
10449 Johnson Avenue South
Bloomington, MN55437
Hennepin County, 27

**Establishment Info:**
ID #: 0039380
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 6513152649
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 SHELL EGGS STORED ABOVE READY TO EAT PRODUCE. CORRECTED ON SITE.

*Comply By: 04/26/22*

**4-700 Sanitizing Equipment and Utensils**

4-702.11 ** Priority 1 **

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

FROM CONVERSATIONS WITH EMPLOYEE, THE ESTABLISHMENT HAS BEEN USING TWO BASIN SINK FOR WARE WASHING. DISCONTINUE AND USE DISHWASHER.

*Comply By: 04/26/22*

**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.

DID NOT HAVE APPROPRIATE TEST KIT FOR TESTING BLEACH CONCENTRATION. OBTAIN AND USE TEST KIT SO BLEACH SOLUTION MEASURES BETWEEN 50 AND 100 PPM.

*Comply By: 04/26/22*

**Surface and Equipment Sanitizers**

Chlorine: = 200 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Type: Full
Date: *04/26/22*
Time: 15:22:19
Report: 7963221048
Midwest Residential Inc

# Food and Beverage Establishment Inspection Report

**Food and Equipment Temperatures**

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: REFRIGERATOR- KITCHEN
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR- BASEMENT
Violation Issued: No

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

The inspection was completed with Faiza Hassan and reviewed with MDH HRD - Nurse Evaluator Mary Bruess.
The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has a plank floor, finished wood cabinets, and solid surface counter tops.
The kitchen finishes and surfaces were well maintained.
A 2 basin sink is located in the kitchen. One basin is designated for hand washing..

Discussed definition of "same day service", hand washing, ware washing, staff illness policy, temperature control, food source, date marking, cleaning, and food handling procedures.

Dishmachine is marked as NSF but has not been used for cleaning and sanitizing. I will mail a test so that it can be determined if the appropriate temperature is reached during the rinse cycle.

Information regarding MN Food Code 4626 and how it applies in a residential setting provided to operators.

**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 7963221048 of 04/26/22.

Certified Food Protection Manager: Susie Johnson

Certification Number: FM 108495 Expires: 09/26/24

**Inspection report reviewed with person in charge and emailed.**

Signed:_____
Faiza Hassan
PIC

Signed:_____
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us