



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

February 18, 2025

Licensee

Minnesota Home And Health Care LLC
6008 Rhode Island Avenue North
Brooklyn Center, MN 55430

RE: Initial License Number 412768
Health Facility Identification Number (HFID) 39995
Project Number(s) SL39995015

Dear Licensee:

On January 02, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed January 02, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective January 02, 2025.

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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

Sincerely,

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

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

December 6, 2024

Licensee

Minnesota Home and Health Care LLC
6008 Rhode Island Avenue North
Brooklyn Center, MN 55430

RE: Provisional Conditional License Number 412768
Health Facility Identification Number (HFID) 39995
Project Number(s) SL39995015

Dear Licensee:

Please Note: This notice amends the notice dated November 25, 2024. Specifically, correction order tag 0820 was amended to reflect accurate bedroom numbers 2 and 3. Previous documentation was noted as bedrooms 1 and 2. Refer to this notice and revised state form for additional details.

The Minnesota Department of Health (MDH) completed a survey on October 8, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **February 23, 2025**.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction 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.

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

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

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

- a. Health Facility Construction Permit:** Minnesota Home and Health Care LLC will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. Within 14 days from the date of this notice,

Minnesota Home and Health Care LLC will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.

b. General Contractor: Minnesota Home and Health Care LLC must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email **within two (2) weeks of the date of this notice:**

- i. Name
- ii. License Number
- iii. Contact Information

c. Egress Window Requirements: Minnesota Home and Health Care LLC will replace at least one window in unoccupied bedrooms 2 and 3, meeting the minimum size requirements.

- i. Must have minimum openable width of no less than 20 inches.
- ii. Must have minimum openable height of no less than 20 inches.
- iii. Must have total openable area of no less than 648 square inches (4.5 square feet).
- iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
- v. All measurements must be achieved under normal operation of opening window without the use of a key, tool, or special knowledge.

d. No new admissions: Minnesota Home and Health Care LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the “no new admissions” condition. Minnesota Home and Health Care LLC must provide the Department:

- i. A list of the names and birthdates of any individuals Minnesota Home and Health Care LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
- ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

- e. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

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

MDH will determine if Minnesota Home and Health Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Minnesota Home and Health Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Minnesota Home and Health Care LLC. If MDH determines Minnesota Home and Health Care LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

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

If you have any questions, please contact Casey DeVries directly at: 651-201-5917.

Sincerely,



Rick Michals, J.D.
Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39995	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER MINNESOTA HOME AND HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6008 RHODE ISLAND AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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 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: SL39995015-0 On October 7, 2024, through October 8, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two resident(s); both of whom were receiving services under the Provisional Assisted Living Facility license. AMENDED Tag 0820 was amended to reflect accurate bedroom numbers 2 and 3. Previous documentation was noted as bedrooms 1 and 2.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor in accordance with Minnesota Administrative Rule 4659.0180 Subpart 3., at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 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 the potential to affect a large portion or all of the residents). The findings include: On October 7, 2024, at 1:31 p.m., licensed assisted living director in residency (LALDIR)-C acknowledged they did not develop and implement a written staffing plan twice a year, and stated, "So, what we have been doing is the quality improvement plans, but we can start doing the staffing plan, we just haven't done it yet." The licensee's Staffing policy, dated April 17, 2023, indicated the clinical nurse supervisor would evaluate the staffing plan and document the review at least twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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	0 480			

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0 480	Continued From page 3 by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=F	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			

Minnesota Department of Health

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0 630	Continued From page 4 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 the required content for two of two residents (R2, R3). 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: R2 R2 was admitted to the licensee and began receiving assisted living services on May 21, 2024. R2's Service Plan, signed by R2 on May 21, 2024, indicated R2 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R2's record lacked an Individual Abuse Prevention Assessment that addressed the resident's susceptibility to abuse by other individuals and risk of abusing other vulnerable	0 630			

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0 630	Continued From page 5 adults or minors, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. R3 R3 was admitted to the licensee and began receiving assisted living services on June 21, 2024. R3's undated and unsigned Service Plan, indicated R3 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R3's record lacked an Individual Abuse Prevention Assessment that addressed the resident's susceptibility to abuse by other individuals and risk of abusing other vulnerable adults or minors, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On October 7, 2024, at 1:06 p.m., licensed assisted living director in residency (LALDIR)-C stated, "As for the IAPP we have not done them, we will work on that." The licensee's Comprehensive Nursing Assessment policy, dated April 17, 2023, indicated the registered nurse would conduct a comprehensive assessment utilizing a uniform assessment tool that included a vulnerability assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630			

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0 630	Continued From page 6 days	0 630			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for four of four employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

Minnesota Department of Health

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0 650	Continued From page 7 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: ULP-B ULP-B was hired and began providing assisted living services on September 9, 2024. On October 7, 2024, at 12:05 p.m., the surveyor observed ULP-B administer medications to R2. ULP-E ULP-E was hired and began providing assisted living services on March 26, 2024. ULP-F ULP-F was hired and began providing assisted living services on March 26, 2024. ULP-G ULP-G was hired and began providing assisted living services on May 27, 2024. ULP-B, ULP-E, ULP-F and ULP-G's employee records lacked the following documentation of required training completed by a registered nurse (RN): - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic infection control, including blood-borne pathogens;	0 650			

Minnesota Department of Health

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0 650	Continued From page 8 - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; - awareness of commonly used health technology equipment and assistive devices; - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and	0 650			

Minnesota Department of Health

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0 650	Continued From page 9 - range of motioning and positioning. On October 8, 2024, at 9:07 a.m., ULP-B stated, "The nurse came out and trained me in a face-to-face discussion and went over the procedure and watched me do the tasks, I did it twice. She watched me do the medications and how to do the blood sugar testing and the dosage for it. She trained me how to contact the nurse, she also trained me on all the cares that could be done with the people I care for and had me show her how to do it. She trained me on all of it, how to take them to the washroom and wash up, get dressed, all those things." On October 8, 2024, at 9:25 a.m., licensed assisted living director in residency (LALDIR)-C stated, "The competencies have been completed by the nurse I just have to look for the paperwork, I will look for it and send it to you." On October 8, 2024, at 11:15 a.m., registered nurse (RN)-A stated, "Competencies are done during orientation, So I did [ULP-B's] training and we go through general orientation, and then we go through all the competencies and I assess that they are doing each competency correctly and then once that is done then they are good to do that task." The licensee's Staff Orientation and Education policy dated April 17, 2023, indicated all clinical topics would be addressed by the registered nurse and documented, signed, and dated, and retained in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

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0 660 SS=F	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 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 screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for four of four employees, (unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 660			

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0 660	Continued From page 11 or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired and began providing assisted living services on September 9, 2024. On October 7, 2024, at 12:05 p.m., the surveyor observed ULP-B administer medications to R2. ULP-B's employee records lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. ULP-E ULP-E was hired and began providing assisted living services on March 26, 2024. ULP-E's employee records lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. ULP-F ULP-F was hired and began providing assisted living services on March 26, 2024. ULP-F's employee records contained a TB QuantiFERON Gold test result dated June 19, 2023, and lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. ULP-G ULP-G was hired and began providing assisted living services on May 27, 2024. ULP-G's employee records lacked evidence of screening for active TB with either a two-step	0 660			

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0 660	Continued From page 12 TST or blood test within 90 days of hire. On October 7, 2024, at 10:45 a.m., licensed assisted living director in residency (LALDIR)-C stated, "[ULP-B] is working today and tomorrow. We scheduled [ULP-B] for her TB test, but she hasn't been able to get it yet." On October 8, 2024, at 9:28 a.m., LALDIR-C stated there were other employees who had their appointments made but had not completed the testing. The licensee's Tuberculosis Screening/Prevention policy dated April 17, 2023, indicated "[Licensee] will observe the recommended precautions related to TB prevention as identified by the centers of Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH)." In addition, the policy indicated "Baseline TB Testing: Baseline TB screening at the time of hire is required for all HCWs in Minnesota. Baseline TB screening consists of three components: (1) assessing for current symptoms of active TB disease, and (2) assessing TB history and 3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test." The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

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0 660	Continued From page 13 (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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors.	0 680			

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0 680	Continued From page 14 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: The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: - Identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - Identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - Develop/implement EP policies/procedures (P/P) to address the following whether evacuated or shelter in place for staff/residents: - Food, water, medical supplies, pharmaceutical supplies - Alternate sources of energy to maintain: - Temperatures to protect resident health/safety; - Safe/sanitary storage of provisions; - Emergency lighting; - Fire detection, extinguishing, alarm systems; and - Sewage and waste disposal; - Develop/implement EP P/P to address the use of volunteers and other emergency staffing strategies; - Develop a communication plan that includes all the following names/contact information: staff, entities providing services under agreement,	0 680			

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0 680	Continued From page 15 residents' physicians, other facilities, volunteers; - Develop and maintain EP training and testing program; - Provide training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role; - Maintain documentation of all EP training; - Demonstrate staff knowledge of EP; - Exercises to test the EP at least twice per year, including unannounced staff drills using the EP that include the following: - Participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On October 7, 2024, at 1:33 p.m., licensed assisted living director in residency (LALDIR)-C stated, "No, we don't have that done yet, but we can get the missing items added, we can work on that. We are putting it together; we don't have a full-scale drill together but some small-scale drills we are working on, and we will add it to the list." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights;	0 730			

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0 730	Continued From page 17 (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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 was admitted to the licensee on March 13, 2024, and discharged on June 10, 2024. R1's record lacked a discharge summary that complied with Minnesota Administrative Rule 4659.0120, Subpart 9 to include: - diagnoses; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the	0 730			

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0 730	Continued From page 18 latest assessment or review including baseline and current mental, behavioral, and functional status. On October 7, 2024, at 1:17 p.m., licensed assisted living director in residency (LALDIR)-C stated, "I do not have a discharge summary because we kept going back and forth as he just left and wouldn't come back and let us discharge him properly, and we didn't manage his medications as he refused to let us. So, one day he just called us and told us to discharge him, and he wasn't coming back." The licensee's Discharge and Transfer of Residents policy, dated April 17, 2023, indicated "A Discharge Summary will be completed by the RN for all residents discharged from assisted living. A copy of the Discharge Summary will be provided to the resident and, with the resident's consent to the resident's representatives and case manager and will be made available to the resident's healthcare practitioner. The Discharge Summary shall include: a. A summary of the resident's stay that includes: i. Diagnoses, ii. Courses of illness iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab, radiology and consultation results b. A final summary of the resident's status from the last assessment or review, including baseline and current mental, behavioral and functional status c. A reconciliation of all predischARGE medications with the resident's post discharge prescribed and over the counter medications d. A post discharge plan developed with the	0 730			

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0 730	Continued From page 19 resident, and with the resident's consent, the resident's representatives to help the resident adjust to a new living environment. The plan must indicate: i. Where the resident plans to reside ii. Any arrangements made for follow-up care iii. Post discharge medical and nonmedical services needed by the resident." No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story 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,	0 780			

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0 780	Continued From page 20 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 smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 October 08, 2024, at 9:55 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director in residency (LALDIR)-C. LALDIR-C tested the smoke alarms throughout the home. Upon testing, the smoke alarms it was found that they were not working properly and failed to be interconnected throughout the facility. These deficient conditions were verified by LALDIR-C accompanying on the tour and he stated that he understood the smoke alarm requirements. No further information was provided.	0 780			

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0 780	Continued From page 21	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, 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 October 08, 2024, at 9:55 a.m. to 11:45 a.m.,	0 790			

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0 790	Continued From page 22 survey staff toured the facility with licensed assisted living director in residency (LALDIR)-C and observed that the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that monthly and annual inspections had been performed as required. The last date documented for an annual inspection was March 2023. Monthly inspections were documented on the basement fire extinguisher log for May, June, July and August 2024 and the main-floor fire extinguisher log was blank. Annual and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. LALDIR-C stated staff was doing monthly inspections of the fire extinguishers but the documentation showed that it was not being done in a timely manner. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800			

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0 800	Continued From page 23 by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, 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 October 08, 2024, at 9:55 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director in residency (LALDIR)-C. The following was observed. Carpet was soiled on the steps going down to the basement. Shrubs were growing in the window well of bedroom # 4. If not removed it will eventually prevent the egress window from opening. Bottom trim of the egress window in bedroom #4 was broken and coming off. LALDIR-C stated they understood the above-listed deficiencies.	0 800			

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0 800	Continued From page 24	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees 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.	0 810			

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0 810	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 08, 2024, at 9:55 a.m. to 11:45 a.m., licensed assisted living director in residency (LALDIR)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this	0 810			

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0 810	Continued From page 26 facility and provide complete actions for employees to take in the event of a fire or similar emergency. DRILLS and TRAINING: Upon record review LALDIR-C failed to provide documentation showing any training and drills that was offered to employees and residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential	0 820			

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0 820	Continued From page 27 to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 08, 2024, at 9:55 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director in residency (LALDIR)-C. During the tour, survey staff asked LALDIR-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: UNOCCUPIED SLEEPING ROOMS: Bedroom 2: Window measured 26 inches clear width, 21 inches clear height, and 546 square inches total open area. Bedroom 3: Window measured 26 inches clear width, 21 inches clear height, and 546 square inches total open area. The windows in bedrooms 2 and 3 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.	0 820			

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0 820	Continued From page 28 Survey staff explained to LALDIR-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. Smoking Areas: On facility tour with the licensed assisted living director in residency (LALDIR)-C on October 08, 2024, between 9:55 a.m. and 11:45 a.m. it was observed that cigarette butts were found lying on the ground by the back door-steps and on the floor in the shed in the backyard. The surveyor explained to the LALDIR-C, that all cigarette butts shall be properly discarded into an approved container and that cigarette smoking should take place outside in the designated area away from the structure. The deficient condition was visually verified by the LALDIR-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 820			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950			

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0 950	Continued From page 29 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for 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 potential to affect a large portion or all of the residents). The findings include:	0 950			

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0 950	Continued From page 30 R2 R2 was admitted to the licensee and began receiving assisted living services on May 21, 2024. R2's Service Plan, signed by R2 on May 21, 2024, indicated R2 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R3 R3 was admitted to the licensee and began receiving assisted living services on June 21, 2024. R3's undated and unsigned Service Plan, indicated R3 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R2's [Licensee] Assisted Living Contract dated May 23, 2024, and R3's [Licensee] Assisted Living Contract dated June 24, 2024, lacked an area to designate a representative. On October 7, 2024, at 1:10 p.m., licensed assisted living director in residency (LALDIR)-C acknowledged that none of the resident's had an opportunity to designate a representative and stated, "Well they are each their own guardian so do they still need a designated rep form?" No further information was provided.	0 950			

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0 950	Continued From page 31	0 950			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of an unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for four of four employees (unlicensed personnel (ULP)-B, ULP-E, ELP-F, ULP-G).	01440			

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01440	Continued From page 32 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: ULP-B ULP-B was hired and began providing assisted living services on September 9, 2024. On October 7, 2024, at 12:05 p.m., the surveyor observed ULP-B administer medications to R2. ULP-E ULP-E was hired and began providing assisted living services on March 26, 2024. ULP-F ULP-F was hired and began providing assisted living services on March 26, 2024. ULP-G ULP-G was hired and began providing assisted living services on May 27, 2024. ULP-B, ULP-E, ULP-F and ULP-G's records lacked evidence a RN conducted direct supervision within 30 days of performing delegated tasks. On October 8, 2024, at 11:15 a.m., registered nurse (RN)-A stated, "After they have worked for 30 days they have a 30 day supervision [ULP-B]	01440			

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01440	Continued From page 33 hasn't quite been there 30 days so we have not yet done that and for the rest of the staff, that would have been done by the nurse that is on maternity leave." On October 8, 2024, at 1:30 p.m., licensed assisted living director in residency (LALDIR)-C stated, "No, we do not have any of the supervisions done, we will work on that." The licensee's Supervision: Unlicensed Staff policy, dated April 17, 2023, indicated "Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff	01470			

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01470	Continued From page 34 responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01470			

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01470	Continued From page 35 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for four of four employees, (unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B ULP-B was hired and began providing assisted living services on September 9, 2024. On October 7, 2024, at 12:05 p.m., the surveyor observed ULP-B administer medications to R2. ULP-E ULP-E was hired and began providing assisted living services on March 26, 2024. ULP-F ULP-F was hired and began providing assisted living services on March 26, 2024. ULP-G ULP-G was hired and began providing assisted	01470			

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01470	Continued From page 36 living services on May 27, 2024. ULP-B, ULP-E, ULP-F and ULP-G's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - Consumer advocacy services. On October 8, 2024, at 9:30 a.m., licensed assisted living director in residency (LALDIR)-C stated, "That training has not yet been completed for staff; we are still needing to complete it but wanted to document appropriately which is why it is not signed off." The licensee's Staff Orientation and Education policy, dated April 17, 2024, indicated orientation training would include consumer advocacy services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620			

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01620	Continued From page 37 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days for two of two residents (R2, R3). 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: R2 R2 was admitted to the licensee and began receiving assisted living services on May 21, 2024. R2's Service Plan, signed by R2 on May 21, 2024, indicated R2 received services including	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39995	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER MINNESOTA HOME AND HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6008 RHODE ISLAND AVENUE NORTH BROOKLYN CENTER, MN 55430		
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01620	Continued From page 38 assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R2's record included 14-day assessment dated June 4, 2024, and a 90-day Assessment dated September 4, 2024, which indicated 92 days passed between the June 4, 2024, and September 4, 2024, assessments. R3 R3 was admitted to the licensee and began receiving assisted living services on June 21, 2024. R3's undated and unsigned Service Plan, indicated R3 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R3's record included a 14-day assessment dated July 5, 2024, indicating the 94 days had passed between the July 5, 2024, and the start of the survey on October 7, 2024. R3's record lacked a 90 day assessment. On October 7, 2024, at 1:36 p.m., licensed assisted living director in residency (LALDIR)-C stated, "Oh it looks like they are late, we will need to do that." LALDIR-C stated the licensee's clinical nurse supervisor was on leave and unavailable for interview. On October 8, 2024, at 11:15 a.m., registered nurse (RN)-A stated they were available for calls	01620			

Minnesota Department of Health

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01620	Continued From page 39 but had not been into the facility to maintain assessments. The licensee's Assessments and Reassessment policy dated April 17, 2023, indicated "Ongoing resident reassessments must be conducted by an RN (registered nurse) and cannot exceed 90 days from the last date of assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640			

Minnesota Department of Health

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01640	Continued From page 40 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on March 13, 2024, and discharged on June 10, 2024. R1's undated and unsigned Service Plan, indicated R1 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R1's service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided.	01640			

Minnesota Department of Health

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01640	Continued From page 41 R3 R3 was admitted to the licensee and began receiving assisted living services on June 21, 2024. R3's undated and unsigned Service Plan, indicated R3 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R3's current service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. On October 7, 2024, at 1:06 p.m., licensed assisted living director in residency (LALDIR)-C stated, "We have a service plan for her (R3) but she has not yet signed it. We are still waiting for her to do that. [R1] was not willing to sign his so we never got a signature." The licensee's Service Plan policy, dated April 17, 2023, indicated "The initial Service plan and any revisions are signed by a representative from [licensee] and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

Minnesota Department of Health

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01910	Continued From page 42	01910			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01910			

Minnesota Department of Health

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01910	Continued From page 43 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 to the licensee on March 13, 2024, and discharged on June 10, 2024. R1's undated and unsigned Service Plan, indicated R1 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R1's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On October 7, 2024, at 1:17 p.m., licensed assisted living director in residency (LALDIR)-C stated, "Yes, we did bill for his meds, when he came we had the doctor's orders and to take over his medications and we were doing that but when he left he refused to let us do any of the steps for discharge including his meds." The licensee's Disposition and Disposal of Medications policy dated April 17, 2023, indicated "Unused portions of current medications being managed by the facility will be given to the resident or responsible party when the resident's Service plan ends, medication management services are no longer provided under the Service	01910			

Minnesota Department of Health

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01910	Continued From page 44 plan or upon discharge; and a note regarding this is placed in the clinical record." In addition, the policy indicated "Upon disposition, [licensee] will document the following information in the clinical record [sic] a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

November 25, 2024

Licensee

Minnesota Home and Health Care LLC
6008 Rhode Island Avenue North
Brooklyn Center, MN 55430

RE: Provisional Conditional License Number 412768
Health Facility Identification Number (HFID) 39995
Project Number(s) SL39995015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 8, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **February 23, 2025**.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.

- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction 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.

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

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

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

- a. **Health Facility Construction Permit:** Minnesota Home and Health Care LLC will contact the Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 362B.103, Subd. 13, and obtain a construction permit for a health facility. Within 14 days from the date of this notice, Minnesota Home and Health Care LLC will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.
- b. **General Contractor:** Minnesota Home and Health Care LLC must provide the following to Tim Hanna, (Tim.Hanna@state.mn.us) via email **within two (2) weeks of the date of this notice:**
 - i. Name
 - ii. License Number
 - iii. Contact Information
- c. **Egress Window Requirements:** Minnesota Home and Health Care LLC will replace at least one window in unoccupied bedrooms 1 and 2, meeting the minimum size requirements.
 - i. Must have minimum openable width of no less than 20 inches.
 - ii. Must have minimum openable height of no less than 20 inches.
 - iii. Must have total openable area of no less than 648 square inches (4.5 square feet).

- iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening.
 - v. All measurements must be achieved under normal operation of opening window without the use of a key, tool, or special knowledge.
- d. No new admissions:** Minnesota Home and Health Care LLC will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the “no new admissions” condition. Minnesota Home and Health Care LLC must provide the Department:
- i. A list of the names and birthdates of any individuals Minnesota Home and Health Care LLC is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services
 - 4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 - 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- e. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

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

MDH will determine if Minnesota Home and Health Care LLC is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Minnesota Home and Health Care LLC is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Minnesota Home and Health Care LLC. If MDH determines Minnesota Home and Health Care LLC is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

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

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

If you have any questions, please contact Casey DeVries directly at: 651-201-5917.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39995	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024
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0 000	Initial Comments 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: SL39995015-0 On October 7, 2024, through October 8, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two resident(s); both of whom were receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor in accordance with Minnesota Administrative Rule 4659.0180 Subpart 3., at least twice a year. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 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 the potential to affect a large portion or all of the residents). The findings include: On October 7, 2024, at 1:31 p.m., licensed assisted living director in residency (LALDIR)-C acknowledged they did not develop and implement a written staffing plan twice a year, and stated, "So, what we have been doing is the quality improvement plans, but we can start doing the staffing plan, we just haven't done it yet." The licensee's Staffing policy, dated April 17, 2023, indicated the clinical nurse supervisor would evaluate the staffing plan and document the review at least twice a year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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	0 480			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER MINNESOTA HOME AND HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6008 RHODE ISLAND AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
0 480	Continued From page 3 by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 630 SS=F	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 4 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 the required content for two of two residents (R2, R3). 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: R2 R2 was admitted to the licensee and began receiving assisted living services on May 21, 2024. R2's Service Plan, signed by R2 on May 21, 2024, indicated R2 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R2's record lacked an Individual Abuse Prevention Assessment that addressed the resident's susceptibility to abuse by other individuals and risk of abusing other vulnerable	0 630			

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0 630	Continued From page 5 adults or minors, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. R3 R3 was admitted to the licensee and began receiving assisted living services on June 21, 2024. R3's undated and unsigned Service Plan, indicated R3 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R3's record lacked an Individual Abuse Prevention Assessment that addressed the resident's susceptibility to abuse by other individuals and risk of abusing other vulnerable adults or minors, and the specific measures to be taken to minimize the risk of abuse to the resident or other vulnerable adults and risk of self-abuse. On October 7, 2024, at 1:06 p.m., licensed assisted living director in residency (LALDIR)-C stated, "As for the IAPP we have not done them, we will work on that." The licensee's Comprehensive Nursing Assessment policy, dated April 17, 2023, indicated the registered nurse would conduct a comprehensive assessment utilizing a uniform assessment tool that included a vulnerability assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 630			

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0 630	Continued From page 6 days	0 630			
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for four of four employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650			

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0 650	Continued From page 7 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: ULP-B ULP-B was hired and began providing assisted living services on September 9, 2024. On October 7, 2024, at 12:05 p.m., the surveyor observed ULP-B administer medications to R2. ULP-E ULP-E was hired and began providing assisted living services on March 26, 2024. ULP-F ULP-F was hired and began providing assisted living services on March 26, 2024. ULP-G ULP-G was hired and began providing assisted living services on May 27, 2024. ULP-B, ULP-E, ULP-F and ULP-G's employee records lacked the following documentation of required training completed by a registered nurse (RN): - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - basic infection control, including blood-borne pathogens;	0 650			

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0 650	Continued From page 8 - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; - awareness of commonly used health technology equipment and assistive devices; - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and	0 650			

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0 650	Continued From page 9 - range of motioning and positioning. On October 8, 2024, at 9:07 a.m., ULP-B stated, "The nurse came out and trained me in a face-to-face discussion and went over the procedure and watched me do the tasks, I did it twice. She watched me do the medications and how to do the blood sugar testing and the dosage for it. She trained me how to contact the nurse, she also trained me on all the cares that could be done with the people I care for and had me show her how to do it. She trained me on all of it, how to take them to the washroom and wash up, get dressed, all those things." On October 8, 2024, at 9:25 a.m., licensed assisted living director in residency (LALDIR)-C stated, "The competencies have been completed by the nurse I just have to look for the paperwork, I will look for it and send it to you." On October 8, 2024, at 11:15 a.m., registered nurse (RN)-A stated, "Competencies are done during orientation, So I did [ULP-B's] training and we go through general orientation, and then we go through all the competencies and I assess that they are doing each competency correctly and then once that is done then they are good to do that task." The licensee's Staff Orientation and Education policy dated April 17, 2023, indicated all clinical topics would be addressed by the registered nurse and documented, signed, and dated, and retained in the employee record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

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0 660 SS=F	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 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 screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for four of four employees, (unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 660			

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0 660	Continued From page 11 or has the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired and began providing assisted living services on September 9, 2024. On October 7, 2024, at 12:05 p.m., the surveyor observed ULP-B administer medications to R2. ULP-B's employee records lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. ULP-E ULP-E was hired and began providing assisted living services on March 26, 2024. ULP-E's employee records lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. ULP-F ULP-F was hired and began providing assisted living services on March 26, 2024. ULP-F's employee records contained a TB QuantiFERON Gold test result dated June 19, 2023, and lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire. ULP-G ULP-G was hired and began providing assisted living services on May 27, 2024. ULP-G's employee records lacked evidence of screening for active TB with either a two-step	0 660			

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0 660	Continued From page 12 TST or blood test within 90 days of hire. On October 7, 2024, at 10:45 a.m., licensed assisted living director in residency (LALDIR)-C stated, "[ULP-B] is working today and tomorrow. We scheduled [ULP-B] for her TB test, but she hasn't been able to get it yet." On October 8, 2024, at 9:28 a.m., LALDIR-C stated there were other employees who had their appointments made but had not completed the testing. The licensee's Tuberculosis Screening/Prevention policy dated April 17, 2023, indicated "[Licensee] will observe the recommended precautions related to TB prevention as identified by the centers of Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH)." In addition, the policy indicated "Baseline TB Testing: Baseline TB screening at the time of hire is required for all HCWs in Minnesota. Baseline TB screening consists of three components: (1) assessing for current symptoms of active TB disease, and (2) assessing TB history and 3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test." The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

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0 660	Continued From page 13 (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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors.	0 680			

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0 680	Continued From page 14 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: The licensee's undated emergency disaster preparedness plan lacked evidence of the following required content: - Identify at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - Identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - Develop/implement EP policies/procedures (P/P) to address the following whether evacuated or shelter in place for staff/residents: - Food, water, medical supplies, pharmaceutical supplies - Alternate sources of energy to maintain: - Temperatures to protect resident health/safety; - Safe/sanitary storage of provisions; - Emergency lighting; - Fire detection, extinguishing, alarm systems; and - Sewage and waste disposal; - Develop/implement EP P/P to address the use of volunteers and other emergency staffing strategies; - Develop a communication plan that includes all the following names/contact information: staff, entities providing services under agreement,	0 680			

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0 680	Continued From page 15 residents' physicians, other facilities, volunteers; - Develop and maintain EP training and testing program; - Provide training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role; - Maintain documentation of all EP training; - Demonstrate staff knowledge of EP; - Exercises to test the EP at least twice per year, including unannounced staff drills using the EP that include the following: - Participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; - Conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On October 7, 2024, at 1:33 p.m., licensed assisted living director in residency (LALDIR)-C stated, "No, we don't have that done yet, but we can get the missing items added, we can work on that. We are putting it together; we don't have a full-scale drill together but some small-scale drills we are working on, and we will add it to the list." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights;	0 730			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 730	Continued From page 17 (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when 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 was admitted to the licensee on March 13, 2024, and discharged on June 10, 2024. R1's record lacked a discharge summary that complied with Minnesota Administrative Rule 4659.0120, Subpart 9 to include: - diagnoses; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the	0 730			

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0 730	Continued From page 18 latest assessment or review including baseline and current mental, behavioral, and functional status. On October 7, 2024, at 1:17 p.m., licensed assisted living director in residency (LALDIR)-C stated, "I do not have a discharge summary because we kept going back and forth as he just left and wouldn't come back and let us discharge him properly, and we didn't manage his medications as he refused to let us. So, one day he just called us and told us to discharge him, and he wasn't coming back." The licensee's Discharge and Transfer of Residents policy, dated April 17, 2023, indicated "A Discharge Summary will be completed by the RN for all residents discharged from assisted living. A copy of the Discharge Summary will be provided to the resident and, with the resident's consent to the resident's representatives and case manager and will be made available to the resident's healthcare practitioner. The Discharge Summary shall include: a. A summary of the resident's stay that includes: i. Diagnoses, ii. Courses of illness iii. Allergies iv. Treatments v. Therapies vi. Pertinent lab, radiology and consultation results b. A final summary of the resident's status from the last assessment or review, including baseline and current mental, behavioral and functional status c. A reconciliation of all predischage medications with the resident's post discharge prescribed and over the counter medications d. A post discharge plan developed with the	0 730			

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0 730	Continued From page 19 resident, and with the resident's consent, the resident's representatives to help the resident adjust to a new living environment. The plan must indicate: i. Where the resident plans to reside ii. Any arrangements made for follow-up care iii. Post discharge medical and nonmedical services needed by the resident." No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story 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,	0 780			

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0 780	Continued From page 20 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 smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 October 08, 2024, at 9:55 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director in residency (LALDIR)-C. LALDIR-C tested the smoke alarms throughout the home. Upon testing, the smoke alarms it was found that they were not working properly and failed to be interconnected throughout the facility. These deficient conditions were verified by LALDIR-C accompanying on the tour and he stated that he understood the smoke alarm requirements. No further information was provided.	0 780			

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0 780	Continued From page 21	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, 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 October 08, 2024, at 9:55 a.m. to 11:45 a.m.,	0 790			

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0 790	Continued From page 22 survey staff toured the facility with licensed assisted living director in residency (LALDIR)-C and observed that the fire extinguishers throughout the facility, did not have current tags or documentation to indicate that monthly and annual inspections had been performed as required. The last date documented for an annual inspection was March 2023. Monthly inspections were documented on the basement fire extinguisher log for May, June, July and August 2024 and the main-floor fire extinguisher log was blank. Annual and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. LALDIR-C stated staff was doing monthly inspections of the fire extinguishers but the documentation showed that it was not being done in a timely manner. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced	0 800			

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0 800	Continued From page 23 by: Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, 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 October 08, 2024, at 9:55 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director in residency (LALDIR)-C. The following was observed. Carpet was soiled on the steps going down to the basement. Shrubs were growing in the window well of bedroom # 4. If not removed it will eventually prevent the egress window from opening. Bottom trim of the egress window in bedroom #4 was broken and coming off. LALDIR-C stated they understood the above-listed deficiencies.	0 800			

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0 800	Continued From page 24	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees 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.	0 810			

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0 810	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 08, 2024, at 9:55 a.m. to 11:45 a.m., licensed assisted living director in residency (LALDIR)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this	0 810			

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0 810	Continued From page 26 facility and provide complete actions for employees to take in the event of a fire or similar emergency. DRILLS and TRAINING: Upon record review LALDIR-C failed to provide documentation showing any training and drills that was offered to employees and residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential	0 820			

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0 820	Continued From page 27 to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 08, 2024, at 9:55 a.m. to 11:45 a.m., survey staff toured the facility with licensed assisted living director in residency (LALDIR)-C. During the tour, survey staff asked LALDIR-C to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: UNOCCUPIED SLEEPING ROOMS: Bedroom 1: Window measured 26 inches clear width, 21 inches clear height, and 546 square inches total open area. Bedroom 2: Window measured 26 inches clear width, 21 inches clear height, and 546 square inches total open area. The windows in bedrooms 1 and 2 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.	0 820			

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0 820	Continued From page 28 Survey staff explained to LALDIR-C that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. Smoking Areas: On facility tour with the licensed assisted living director in residency (LALDIR)-C on October 08, 2024, between 9:55 a.m. and 11:45 a.m. it was observed that cigarette butts were found lying on the ground by the back door-steps and on the floor in the shed in the backyard. The surveyor explained to the LALDIR-C, that all cigarette butts shall be properly discarded into an approved container and that cigarette smoking should take place outside in the designated area away from the structure. The deficient condition was visually verified by the LALDIR-C accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 820			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950			

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0 950	Continued From page 29 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for 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 potential to affect a large portion or all of the residents). The findings include:	0 950			

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0 950	Continued From page 30 R2 R2 was admitted to the licensee and began receiving assisted living services on May 21, 2024. R2's Service Plan, signed by R2 on May 21, 2024, indicated R2 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R3 R3 was admitted to the licensee and began receiving assisted living services on June 21, 2024. R3's undated and unsigned Service Plan, indicated R3 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R2's [Licensee] Assisted Living Contract dated May 23, 2024, and R3's [Licensee] Assisted Living Contract dated June 24, 2024, lacked an area to designate a representative. On October 7, 2024, at 1:10 p.m., licensed assisted living director in residency (LALDIR)-C acknowledged that none of the resident's had an opportunity to designate a representative and stated, "Well they are each their own guardian so do they still need a designated rep form?" No further information was provided.	0 950			

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0 950	Continued From page 31	0 950			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed supervision of an unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for four of four employees (unlicensed personnel (ULP)-B, ULP-E, ELP-F, ULP-G).	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39995	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER MINNESOTA HOME AND HEALTH CARE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 6008 RHODE ISLAND AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
01440	Continued From page 32 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: ULP-B ULP-B was hired and began providing assisted living services on September 9, 2024. On October 7, 2024, at 12:05 p.m., the surveyor observed ULP-B administer medications to R2. ULP-E ULP-E was hired and began providing assisted living services on March 26, 2024. ULP-F ULP-F was hired and began providing assisted living services on March 26, 2024. ULP-G ULP-G was hired and began providing assisted living services on May 27, 2024. ULP-B, ULP-E, ULP-F and ULP-G's records lacked evidence a RN conducted direct supervision within 30 days of performing delegated tasks. On October 8, 2024, at 11:15 a.m., registered nurse (RN)-A stated, "After they have worked for 30 days they have a 30 day supervision [ULP-B]	01440			

Minnesota Department of Health

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01440	Continued From page 33 hasn't quite been there 30 days so we have not yet done that and for the rest of the staff, that would have been done by the nurse that is on maternity leave." On October 8, 2024, at 1:30 p.m., licensed assisted living director in residency (LALDIR)-C stated, "No, we do not have any of the supervisions done, we will work on that." The licensee's Supervision: Unlicensed Staff policy, dated April 17, 2023, indicated "Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff	01470			

Minnesota Department of Health

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01470	Continued From page 34 responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01470			

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01470	Continued From page 35 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for four of four employees, (unlicensed personnel (ULP)-B, ULP-E, ULP-F, ULP-G) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-B ULP-B was hired and began providing assisted living services on September 9, 2024. On October 7, 2024, at 12:05 p.m., the surveyor observed ULP-B administer medications to R2. ULP-E ULP-E was hired and began providing assisted living services on March 26, 2024. ULP-F ULP-F was hired and began providing assisted living services on March 26, 2024. ULP-G ULP-G was hired and began providing assisted	01470			

Minnesota Department of Health

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01470	Continued From page 36 living services on May 27, 2024. ULP-B, ULP-E, ULP-F and ULP-G's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: - Consumer advocacy services. On October 8, 2024, at 9:30 a.m., licensed assisted living director in residency (LALDIR)-C stated, "That training has not yet been completed for staff; we are still needing to complete it but wanted to document appropriately which is why it is not signed off." The licensee's Staff Orientation and Education policy, dated April 17, 2024, indicated orientation training would include consumer advocacy services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs	01620			

Minnesota Department of Health

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01620	Continued From page 37 and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days for two of two residents (R2, R3). 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: R2 R2 was admitted to the licensee and began receiving assisted living services on May 21, 2024. R2's Service Plan, signed by R2 on May 21, 2024, indicated R2 received services including	01620			

Minnesota Department of Health

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01620	Continued From page 38 assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R2's record included 14-day assessment dated June 4, 2024, and a 90-day Assessment dated September 4, 2024, which indicated 92 days passed between the June 4, 2024, and September 4, 2024, assessments. R3 R3 was admitted to the licensee and began receiving assisted living services on June 21, 2024. R3's undated and unsigned Service Plan, indicated R3 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R3's record included a 14-day assessment dated July 5, 2024, indicating the 94 days had passed between the July 5, 2024, and the start of the survey on October 7, 2024. R3's record lacked a 90 day assessment. On October 7, 2024, at 1:36 p.m., licensed assisted living director in residency (LALDIR)-C stated, "Oh it looks like they are late, we will need to do that." LALDIR-C stated the licensee's clinical nurse supervisor was on leave and unavailable for interview. On October 8, 2024, at 11:15 a.m., registered nurse (RN)-A stated they were available for calls	01620			

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01620	Continued From page 39 but had not been into the facility to maintain assessments. The licensee's Assessments and Reassessment policy dated April 17, 2023, indicated "Ongoing resident reassessments must be conducted by an RN (registered nurse) and cannot exceed 90 days from the last date of assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640			

Minnesota Department of Health

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01640	Continued From page 40 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on March 13, 2024, and discharged on June 10, 2024. R1's undated and unsigned Service Plan, indicated R1 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R1's service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided.	01640			

Minnesota Department of Health

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01640	Continued From page 41 R3 R3 was admitted to the licensee and began receiving assisted living services on June 21, 2024. R3's undated and unsigned Service Plan, indicated R3 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R3's current service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided. On October 7, 2024, at 1:06 p.m., licensed assisted living director in residency (LALDIR)-C stated, "We have a service plan for her (R3) but she has not yet signed it. We are still waiting for her to do that. [R1] was not willing to sign his so we never got a signature." The licensee's Service Plan policy, dated April 17, 2023, indicated "The initial Service plan and any revisions are signed by a representative from [licensee] and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			

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01910	Continued From page 42	01910			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	01910			

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01910	Continued From page 43 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 to the licensee on March 13, 2024, and discharged on June 10, 2024. R1's undated and unsigned Service Plan, indicated R1 received services including assistance with housekeeping, laundry, shopping, making appointments, transportation, meals, grooming, bathing, assistance with medication administration, medication set-up and monitoring, and behavior monitoring. R1's record lacked a medication disposition to include the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On October 7, 2024, at 1:17 p.m., licensed assisted living director in residency (LALDIR)-C stated, "Yes, we did bill for his meds, when he came we had the doctor's orders and to take over his medications and we were doing that but when he left he refused to let us do any of the steps for discharge including his meds." The licensee's Disposition and Disposal of Medications policy dated April 17, 2023, indicated "Unused portions of current medications being managed by the facility will be given to the resident or responsible party when the resident's Service plan ends, medication management services are no longer provided under the Service	01910			

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01910	Continued From page 44 plan or upon discharge; and a note regarding this is placed in the clinical record." In addition, the policy indicated "Upon disposition, [licensee] will document the following information in the clinical record [sic] a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

Type: Full
Date: 10/08/24
Time: 08:58:42
Report: 1023241224

Food and Beverage Establishment Inspection Report

Page 1

Location:

Minnesota Home and Health Care
6008 Rhode Island Ave N
New Hope, MN55428
Hennepin County, 27

Establishment Info:

ID #: 0043696
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

OBSERVED RAW SHELL EGGS STORED OVER READY TO EAT FOODS SUCH AS FRUIT.
OPERATOR MOVED EGGS TO SAFE LOCATION.

Comply By: 10/08/24

2-500 Responding to contamination events

2-501.11 ** Priority 2 **

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

SENT SAMPLE PLAN WITH REPORT.

Comply By: 10/08/24

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

CHLORINE SANITIZER IN USE BUT NO TEST STRIPS AVAILABLE. ACQUIRE AND USE THESE TO ENSURE PATHOGEN DESTRUCTION.

Comply By: 10/08/24

Type: Full
Date: 10/08/24
Time: 08:58:42
Report: 1023241224
Minnesota Home and Health Care

Food and Beverage Establishment Inspection Report

Page 2

4-100 Equipment Construction Materials

4-101.17

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

INSTRUCTED OPERATOR TO DISCARD WOOD CUTTING BOARD.

Comply By: 10/08/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit

Location: SPRAY

Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit

Location: ANSI 184

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK

Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER

Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY DOES NOT HAVE ALL COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED. FOOD SERVICE IS PROVIDED BY FACILITY STAFF.

FOOD SERVICE AREA FLOORS, WALLS, CEILINGS, COUNTERTOPS, AND FINISH MATERIALS MUST BE NON-ABSORBANT, SMOOTH, DURABLE, AND EASILY CLEANABLE. CEILINGS CANNOT HAVE POPCORN TEXTURE. CABINETS CANNOT HAVE HOLLOW BASES. EXPOSED WOOD IS NOT APPROVED FOR FOOD SERVICE AREAS. WOOD IS NOT AN APPROVED FOOD CONTACT SURFACE.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- ANSI 184 DISH WASHER

Type: Full
Date: 10/08/24
Time: 08:58:42
Report: 1023241224
Minnesota Home and Health Care

Food and Beverage Establishment Inspection Report

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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 1023241224 of 10/08/24.

Certified Food Protection Manager SELEKIE KAMARA

Certification Number: 113625 Expires: 11/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

LOMBEH WILSON
PERSON IN CHARGE

Signed: Gregory T Nelson

Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us