



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 5, 2024

Licensee

First Light Residential Care
2935 Aquila Avenue South
Saint Louis Park, MN 55426

RE: Project Number(s) SL35226015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH note violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

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

If you have any questions, please contact me.

Sincerely,

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

Kelly Thorson, Supervisor

State Evaluation Team

Email: kelly.thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2023
NAME OF PROVIDER OR SUPPLIER FIRST LIGHT RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2935 AQUILA AVENUE SOUTH SAINT LOUIS PARK, MN 55426			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL35226015 On December 18, 2023, through December 19, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; all receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 18, 2023, 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			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for	0 550			

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0 550	Continued From page 2 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee lacked a posting of the grievance procedure, including the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. On December 18, 2023, during the facility tour at	0 550			

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0 550	Continued From page 3 11:00 a.m., the surveyor observed the entry area and common areas within the facility and noted there was no required posting of the grievance procedure. On December 18, 2023, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had gotten a new enclosed cork board for their postings and forgot to post about their grievance and complaint policy. The licensee's Grievance policy dated August 1, 2021, indicated a copy of the grievance procedure is conspicuously posted in the residence with the following information, name, telephone number, and email contact information for the individuals who are responsible for handling resident complaints. Contact information for the state and any regional Office of Ombudsman for Long Term Care. Contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities. Contact information for the Minnesota Adult Abuse Reporting Center. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that	0 580			

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0 580	Continued From page 4 have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 19, 2023, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they do have quality management meetings, but was unaware they needed to have documentation of them. The licensee's Quality Improvement policy dated August 1, 2021, indicated [the facility] has established a quality improvement program based on the organization's size and appropriate to the type of services provided. Documentation	0 580			

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0 580	Continued From page 5 of the Quality Improvement Program is maintained for at least two years and will be provided to the commissioner at the time of survey, investigation or renewal as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
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 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), which included an updated TB risk assessment for the facility.	0 660			

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0 660	Continued From page 6 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: The facility TB risk assessment was partially completed September 28, 2021, with only the first of four pages filled out. The facility TB risk assessment had not been updated since. On December 18, 2023, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she was aware only the first page of the risk assessment had been filled out and knew it needed to be completed. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated the director is responsible for conducting the formal TB Risk Assessment and updating it annually. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before	0 660			

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0 660	Continued From page 7 hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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.	0 680			

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0 680	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to impact all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 19, 2023, at 1:40 p.m. licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they had not fully developed the emergency preparedness plan. They had sent information to their consultant who had been helping them develop the emergency plan. LALD/CNS-A further stated some of the information is stored in the computer and it is not accessible to others. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated [the facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680			

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0 680	Continued From page 9 (21) days	0 680			
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 perform the required monthly maintenance on fire extinguishers. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 790			

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0 790	Continued From page 10 On December 18, 2023, at 12:00 p.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, it was observed the portable fire extinguishers were tagged, showing the required annual service but lacked records to show the required monthly visual inspections were performed or recorded for all portable fire extinguishers throughout buildings. On December 18, 2023, at 12:00 p.m., LALD/CNS-A verified required maintenance had not been completed. 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 by: Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.	0 800			

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0 800	Continued From page 11 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 December 18, 2023, at 12:00 p.m., survey staff toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, survey staff observed the following: Outside the exit door, it was observed burnt used cigarettes were being disposed of all over the area without a proper disposal container, creating a possible fire hazard. In the bathroom on the main level, it was observed the gypsum walls were severely damaged, evident by the steel frame exposure. On December 18, 2023, at 12:00 p.m., LALD/CNS-A verified the lack of proper disposal of cigarettes and damage to the bathroom wall. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810			

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0 810	Continued From page 12 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors.	0 810			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2023
NAME OF PROVIDER OR SUPPLIER FIRST LIGHT RESIDENTIAL CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 2935 AQUILA AVENUE SOUTH SAINT LOUIS PARK, MN 55426		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 13 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 December 19, 2023, at 12:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP 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 fire safety and evacuation plan was a third-party consultant provided plan, and it was not updated to meet the facility-specific layout. The fire safety and evacuation plan included the RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP and the posted evacuation plans did not show the location and number of resident rooms. During the interview on December 19, 2023, at	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2023
NAME OF PROVIDER OR SUPPLIER FIRST LIGHT RESIDENTIAL CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2935 AQUILA AVENUE SOUTH SAINT LOUIS PARK, MN 55426			
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0 810	Continued From page 14 12:00 p.m., LALD/CNS-A stated she thought the facility updated the FSEP to the facility's building layout and environmental risks. LALD/CNS-A stated she provided the not-edited version of the file and stated the revised FSEP would be provided via email as a follow-up. But no follow-up email was received from the facility. TRAINING Record review of the available documentation indicated employees did not receive training twice yearly after initial hire. In the provided FSEP, the facility policy required the staff training to be conducted at orientation and annually after. Employee training records were requested, and no training records were provided. During the interview on December 19, 2023, at 12:00 p.m., LALD/CNS-A stated the facility provided two fire safety training to staff, and the staff training record would be provided via email as a follow-up. But no follow-up email was received from the facility. DRILLS Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 8/15/23, 2/7/23, 8/11/22, 2/5/22, and 8/1/21 with no further drills being documented. During the interview on December 19, 2023, at 12:00 p.m., LALD/CNS-A confirmed that the drills were conducted every six months only and verified there were no further documented drills for the facility.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2023
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0 810	Continued From page 15	0 810			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted for services on November 30, 2020. R1's Service Plan dated October 22, 2022, indicated R1 received services to include medication administration. On December 19, 2023, at 11:10 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1.	01830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35226	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/19/2023
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01830	Continued From page 16 R1's December 2023 medical administration record showed the following medications: -lamotrigine 200 milligrams (mg) twice daily -topiramate 100 mg twice daily -desvenlafaxine 100 mg and 50mg daily -olanzapine 40 mg daily R1's record showed signed orders for desvenlafaxine and olanzapine dated July 19, 2022, and signed orders for lamotrigine and topiramate dated December 14, 2020. R1's record also showed an electronic prescription from the pharmacy for an updated dose for topiramate dated November 21, 2023. On December 19, 2023, at 10:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she had been working on getting current signed orders, but it is hard getting a signature back from the provider. LALD/CNS-A further stated she is working on going to appointments with the residents to get the orders signed. LALD/CNS-A stated she knows they are late. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated medication and treatment orders will be renewed at least every year or when changes occur. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830			

Type: Full
Date: 12/18/23
Time: 13:39:46
Report: 1036231319

Food and Beverage Establishment Inspection Report

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Location:

First Light Residential Care
2935 Aquila Avenue South
St Louis Park, MN55426
Hennepin County, 27

Establishment Info:

ID #: 0037459
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6124047552
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 EGGS BEING STORED ABOVE RTE IN FOODS IN FRIDGE #1. ADVISED TO MOVE TO LOWEST SHELF OR STORE IN A CONTAINER.

Comply By: 12/19/23

3-500C Microbial Control: date marking

3-501.17B ** Priority 2 **

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

OBSERVED AN OPEN BAG OF SHREDDED CHEESE IN FRIDGE #1 WITH NO DATE LABEL.
COMPLY WITH ABOVE RULE.

Comply By: 12/19/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO DEVICE FOR MEASURING UST IN DISH MACHINE. PROVIDE AND MAINTAIN.

Comply By: 01/08/24

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4-200 Equipment Design and Construction

4-204.112D

MN Rule 4626.0620D Provide a temperature measuring device that is easily readable.

NO FOOD THERMOMETER AT ESTABLISHMENT. PROVIDE AND MAINTAIN.

Comply By: 01/08/24

Surface and Equipment Sanitizers

UTENSIL SURFACE TEMP: = at 160 Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Chlorine: = 100PPM at Degrees Fahrenheit

Location: SANITIZER BUCKET

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK

Temperature: 37 Degrees Fahrenheit - Location: FRIDGE #2

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 4 Degrees Fahrenheit - Location: FREEZER #2

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 36 Degrees Fahrenheit - Location: FRIDGE #2

Violation Issued: No

Process/Item: Ambient Temp

Temperature: 2 Degrees Fahrenheit - Location: FREEZER #2

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. SURVEYOR FROM HRD WAS WENDY ROBARGE. INSPECTION CONDUCTED IN PRESENCE OF SHAMSO HASSAN, THE PERSON IN CHARGE. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE AND HRD EVALUATOR DURING INSPECTION.

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

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH THE PERSON IN CHARGE:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.

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- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

****IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.**

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

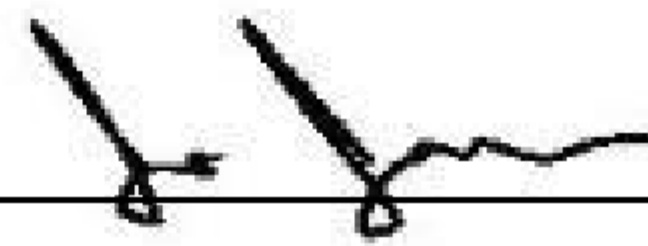
I acknowledge receipt of the inspection report number 1036231319 of 12/18/23.

Certified Food Protection Manager Shamso M. Hassan

Certification Number: FM111609 Expires: 08/19/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Shamso M. Hassan
Person in Charge

Signed:  _____
Jeff Johanson