Electronically Delivered

March 27, 2025

Licensee
Twins Home Care Service LLC
13413 Parkwood Drive
Burnsville, MN 55337

RE: Project Number(s) SL37960016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37960	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINS HOME CARE SERVICE LLC	13413 PARKWOOD DRIV BURNSVILLE, MN 55337

(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: SL37960016-0 On February 18, 2025, through February 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (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 observation, interview, and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 680		

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0 680	Continued From page 2 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On February 18, 2025, at 11:30 a.m. during the entrance conference, the licensee's emergency preparedness plan and Appendix Z was discussed. Licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she and manager (M)-B created and managed the facility's emergency preparedness (EP) plan. During a tour of the facility on February 18, 2025, at 12:30 p.m., the surveyor observed postings on the wall of the main floor of the facility. A copy of the licensee's EP plan was pinned to a bulletin board in both the living room and kitchen areas. On February 20, 2025, at 9:30 a.m., the surveyor requested the licensee's full EP plan. Manager (M)-B provided two binders with various documents and stated both binders included the required EP material/plan. The surveyor reviewed the contents of both binders and noted the EP plan lacked any date to indicate when it was developed or reviewed and lacked the following required content according to Emergency Preparedness: Appendix Z: - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - policy and procedure based on the EP risk assessment and communication plan; - policy and procedure addressing whether evacuated or shelter in place for staff/residents	0 680		

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0 680	Continued From page 3 for food, water, medical supplies, pharmaceutical supplies; - policy and procedure addressing alternate sources of energy to maintain temperatures to protect resident health/safety, safe and sanitary storage of provisions emergency lighting and sewage and waste disposal; - policy and procedure addressing safe evacuation from facility, including care and treatment needs of evacuees; staff responsibilities; primary/alternate communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure addressing system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy and procedure addressing use of volunteers, including the process/role for integration; - policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; - develop a written communication plan; - communication plan which includes names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - communication plan which includes contact information for Federal, State, tribal, regional and local EP staff; State Licensing and Certification Agency; and other sources of assistance; - communication plan which includes alternate means of communication with facility staff and Federal, State, tribal, regional and local emergency management agencies; - communication plan which includes method for sharing information and medical documentation	0 680		

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0 680	Continued From page 4 for residents under the facility's care, as necessary, with other health care personnel to maintain continuity of care; means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); means of providing information about general condition/location of residents under facility's care as permitted under 45 CFR 164.510(b)(4); - communication plan which includes means to providing information about the facility occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the incident command center, or designee. Furthermore, the licensee's EP plan lacked a Missing Resident Plan/Procedure as required. On February 20, 2025, at 11:00 a.m., LALD/CNS-A reviewed the contents of the licensee's EP plan and Appendix Z required content, and stated the above listed contents were either incomplete or were likely developed but stored elsewhere, and they would update the plan to include the required elements and store in a single binder. The licensee's Emergency Preparedness-Appendix Z Compliance policy dated October 10, 2021, indicated the licensee's emergency preparedness plan will include all required elements of Appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include the four primary components. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code, under Minnesota Rules Chapter 7511. This had the potential to directly affect more than a limited number of 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 February 20, 2025, at 10:30 a.m., the surveyor toured the facility with manager (M)-B. During the tour, the surveyor observed the following: - A power strip without a safety standard listing was used to supply power to the clothes washing machine and clothes dryer. When used, power strips must be listed indicating that the product has been tested and meets safety standards. Power strips must not be overloaded by appliances that require a high amount of electricity to operate. - An extension cord was used to supply power to	0 775		

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0 775	Continued From page 6 the water softener. - In occupied resident room 3, an extension cord was plugged into a multiplug adapter to supply power. Improper use of extension cords and power strips creates a fire hazard. During the tour interview, M-B verified the above listed observations. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 790 SS=E	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 install two portable fire extinguishers as required by statute. This deficient condition had the potential to affect more than a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 790		

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0 790	Continued From page 7 safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 February 20, 2025, at 10:30 a.m., the surveyor toured the facility with manager (M)-B. During the tour, the surveyor observed the following: - In the kitchen, the fire extinguisher was stored on the kitchen counter. - In the basement office, the fire extinguisher was stored on a wall shelf. Fire extinguishers must be available in an emergency and properly installed to prevent them from being moved or damaged. When portable fire extinguishers are mounted on wall brackets, the extinguisher must be at least four inches off the ground and no higher than five feet. During the tour interview, M-B verified the above listed observations. 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	0 800		

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0 800	Continued From page 8 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 provide 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, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 20, 2025, at 10:30 a.m., the surveyor toured the facility with manager (M)-B. During the tour, the surveyor observed the following: - In the garage, the electrical panel was obstructed by items stored in front of the panel. The access area in front of an electrical panel shall have a minimum clearance of at least three feet. - The door for sleeping room 4 and the mechanical room door could not be closed all the way and did not latch. In the event of a fire, doors that are not capable of being closed would allow fire and smoke to travel more quickly through a building.	0 800		

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0 800	Continued From page 9 - In occupied resident room 3, one side of the closet was off the track, posing a safety risk. - One wall outlet cover was chipped in the hallway. - One section of base trim was missing from the floor/wall junction in the entryway area. - In the shared resident bathroom, the toilet paper holder was in disrepair and one light bulb was not working in the light fixture above the sink vanity. - The carpet was soiled and stained in the basement. During the tour interview, M-B verified the above listed observations. 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: (1) location and number of resident sleeping rooms; (2) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 10 (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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, maintain all parts of the plan as readily available, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 20, 2025, manager (M)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on	0 810		

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0 810	Continued From page 11 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 floor plan failed to identify the number of resident sleeping rooms and the main exit for the facility evident by the following: On February 20, 2025, at 10:30 a.m., the surveyor toured the facility with manager (M)-B. During the tour, the surveyor observed numbers were posted at the resident sleeping room doors. These sleeping room numbers were not included on the posted FSEP floor plan. Resident sleeping room numbers are required to be labeled on the FSEP floor plan in order to provide efficient communication for exiting in the event of a fire or similar emergency. On February 20, 2025, at 10:30 a.m., the surveyor toured the facility with manager (M)-B. During the tour, the surveyor observed an exit sign was posted at the front door. The posted FSEP floor plan did not label the front door as an emergency exit for the facility. Exit labels are required to be included on the FSEP floor plan in order to direct occupants to the main exit in the event of an emergency. The FSEP included templates from third-party providers and had not been developed for this facility. The licensee FSEP included a 9.06 fire safety policy dated October 10, 2021, a fire safety and evacuation plan policy with a revised date of December 6, 2024, and an emergency/disaster plan for a fire in our AL. The FSEP included standard employee procedures, but failed to provide specific	0 810		

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0 810	Continued From page 12 employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym. The FSEP inappropriately directed the building occupants to only evacuate the entire building upon orders from the administration or fire department and to generally plan to shelter in place in the event of a fire in a building that did not have any fire resistant construction or life safety systems. The FSEP inaccurately referenced smoke compartment doors, fire sprinklers, pull fire alarms, fire doors on magnetic holders, and a system wired to the fire station. The FSEP did not identify specific fire protection procedures necessary for residents relative to the facility's building layout and environmental risks. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency. The evacuation procedures for residents that required assistance were kept electronically as part of their care plan and not maintained readily available. These procedures were not included in the FSEP binder. The posted fire policy identified fire extinguisher locations in the kitchen and laundry room. On February 20, 2025, at 10:30 a.m., the surveyor toured the facility with manager (M)-B. During the tour, the surveyor observed a fire extinguisher was not installed in the laundry room.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37960	A. BUILDING: _____ B. WING _____	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 13 During an interview on February 20, 2025, at 12:30 p.m., M-B verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by a lack of training documentation to support it had been completed. A staff meeting signature page was provided with dates entered for November and December 2024, and January 2025. The signature page did not list any of these meetings as FSEP training. During an interview on February 20, 2025, at 12:30 p.m., M-B verified the employee training records did not include the required documentation. M-B stated new hire employees were trained during fire drills and this was recorded on the fire drill audits. M-B verified FSEP training had not been completed with new employees. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift evident by a review of completed fire drill audits from 2024 and 2025. All of the fire drills had been completed during the 7 a.m.- 3 p.m. and 3 p.m. - 11 p.m. shifts. No drills had been completed during the 11 p.m. - 7 a.m. shift. During an interview on February 20, 2025, at 12:30 p.m., M-B stated some of the fire drills had combined shifts to include the night shift employees. M-B verified drills had not been completed during the night shift and that the evacuation fire drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01290	Continued From page 14	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure four of 17 employees (unlicensed personnel (ULP)-D, ULP-G, ULP-H, ULP-I) were affiliated with the assisted living license as required. This had the potential to affect the licensee's five 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) 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:	01290		

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01290	Continued From page 15 On February 19, 2025, at 9:00 a.m., manager (M)-B provided the surveyor with the licensee's NETStudy roster dated February 19, 2025. ULP-D ULP-D was hired on January 16, 2023, to provide direct care services to the licensee's residents. On February 19, 2025, at 12:15 p.m., ULP-D was observed to administer one oral medication and one topical medication to R4. ULP-D's employee record contained a background study dated January 16, 2023, for health facility identification number (HFID) 39002 (the licensee's other assisted living facility (ALF). ULP-D's record lacked evidence the licensee affiliated a background study for their assisted living facility. ULP-G ULP-G was hired on November 15, 2022, to provide direct care services to the licensee's residents. The licensee's NETStudy roster dated February 19, 2025, indicated ULP-G had a cleared background study completed on December 3, 2022. ULP-G's background clearance was affiliated with the licensee's "sister" facility (HFID-39002). ULP-G's record lacked evidence the licensee affiliated a background study for their assisted living facility. ULP-H ULP-H was hired on September 21, 2023, to provide direct care services to the licensee's	01290		

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	37960	A. BUILDING: _____ B. WING _____	02/20/2025

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01290	Continued From page 16 residents. The licensee's NETStuday roster dated February 19, 2025, indicated ULP-H had a cleared background study completed on October 5, 2023. ULP-H's background clearance was affiliated with the licensee's "sister" facility (HFID-39002). ULP-H's record lacked evidence the licensee affiliated a background study for their assisted living facility. ULP-I ULP-I was hired on February 5, 2024, to provide direct care services to the licensee's residents. The licensee's NETstudy roster dated February 10, 2025, indicated ULP-I had a cleared background study completed on February 12, 2024. ULP-I's background clearance was affiliated with the licensee's "sister" facility (HFID-39002). ULP-I's record lacked evidence the licensee affiliated a background study for their assisted living facility. On February 19, 2025, at 9:30 a.m., M-B stated the above listed employees were initially affiliated with the licensee's "sister" facility and that facility's HFID number; however, the employees worked at both locations and had not yet had their background studies affiliated with this facility/facility HFID. The licensee's Background Study Policy dated October 10, 2021, indicated [licensee name] will conduct a Minnesota Department of Human Services Background Study on all employees and volunteers and contractors at [licensee name].	01290		

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01290	Continued From page 17 No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an insulin pen included an opened date and failed to ensure medications bore an original or proper label 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:	01890		

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01890	Continued From page 18 R1's diagnoses included cerebral infarction (stroke) with hemiplegia (paralysis or weakness on one side of the body), and type 2 diabetes. R1's Service Plan-Addendum to the Contract dated February 10, 2025, included the service of medication administration. On February 19, 2025, at 8:10 a.m., the surveyor observed unlicensed personnel (ULP)-E administer oral medications, and Lispro insulin to R1. R1's insulin pen lacked a proper label and an open date. ULP-E stated she was unsure about when the pen was pulled from the refrigerator and put into use (then stored at room temperature). ULP-E stated she was aware the insulin pens needed an open date. On February 19, 2025, at 1:00 p.m., assisted living director/clinical nurse supervisor (LALD/CNS)-A stated she expected staff to indicate an open date for insulin once removed from the refrigerator and needed to request additional labels from the pharmacy for the insulin pens once removed from the labeled box. R1's signed prescriber's orders dated February 12, 2024, indicated: -Lispro (glargine) insulin, 2 units (u) subcutaneously (injected under the skin) three times daily, and 4 units subcutaneously daily at 4:00 p.m. for diabetes. Lispro insulin manufacturer's instructions dated July 2023, indicated discard insulin pen stored at room temperature after 28 days of use, even if insulin remains in the pen. The licensee's Medication Storage policy dated	01890		

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01890	Continued From page 19 October 10, 2021, indicated when medications are managed and stored by [licensee name], medications will be kept securely locked and stored per manufacturer's directions. Multi use injection vials, pens must be labeled with client name and DOB [dated of birth]. Insulin pens must be labeled with expiration date post opening date should be labeled correctly. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		

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

Type: Full
Date: *02/18/25*
Time: 15:52:14
Report: 1018251024

Food and Beverage Establishment Inspection Report

Location:
Twins Home Care
13413 Parkwood Drive
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0040363
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/22

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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Cold Holding/ MILK
Temperature: 39 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

ESTABLISHMENT IS DOING ALL SAME DAY SERVICE OF FOODS.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN FAIR CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

KITCHEN HAS A TWO BASIN SINK AND ONE SINK SPECIFICALLY FOR HAND WASHING.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE. TEST STRIP INDICATED APPROPRIATE TEMPERATURE WAS ACHIEVED DURING CYCLE.

Food and Beverage Establishment Inspection Report

ESTABLISHMENT HAS A NEEDLE POINT THERMOMETER FOR CHECKING FOOD TEMPERATURES.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED EMPLOYEE ILLNESS LOG.

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

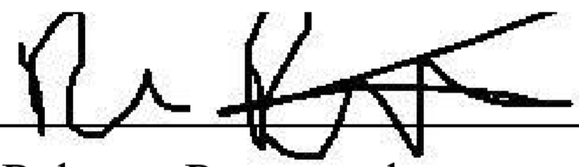
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018251024 of 02/18/25.

Certified Food Protection Manager: BEZA FEWADE MEKONENE

Certification Number: FM120754 Expires: 01/19/27

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed: 

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