Electronically Delivered

January 27, 2025

Licensee
Emalina Cares LLC
2100 55th Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL40708015

Dear Licensee:

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.

The Minnesota Department of Health completed an initial survey on December 12, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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

Per 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

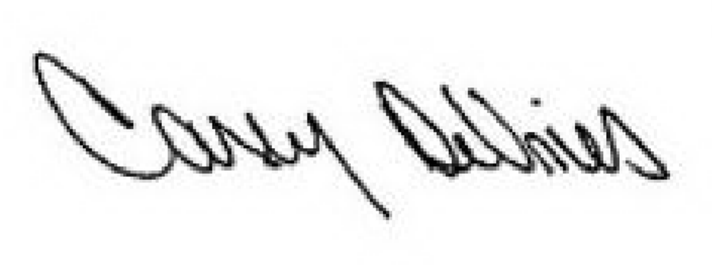
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 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
	40708	A. BUILDING: _____ B. WING _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMALINA CARES LLC	2100 55TH AVE N 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 ******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: SL40708015-0 On December 9, 2024, to December 12, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction are issued. At the time of the survey there were four residents residing at the facility, all of whom received 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 1 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 develop and display prominently a written emergency preparedness (EP) plan with all the required content for staff, residents, and visitors to view. 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	0 680		

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0 680	Continued From page 2 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 9-10, 2024, the surveyor reviewed the licensee's Emergency Preparedness Plan, last updated May 10, 2024, which lacked evidence of the following required information: - quarterly review of the missing resident plan; - must include a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to maintain integrated response; - designation of a qualified person, who is authorized in writing, to act in the absence of the administrator; - identification of which staff would assume specific roles in another's absence through succession planning and delegation of authority; - evacuation location and agreements; - arrangements and agreements with facilities receiving their residents in the event of evacuation; - shelter in place needs; - resident evacuation priority level of assistance; - development of P/P (policy/procedure) for at minimum food, water and pharmaceutical supplies; - EP includes P/P for at minimum food, water, and pharmaceutical supplies; - development of P/P to address: use of volunteers, including the process/role for integration; - development of P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; and - development of a communication plan to include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers.	0 680		

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0 680	Continued From page 3 On December 10, 2024, at 8:41 a.m., assisted living director/licensed practical nurse (ALD/LPN)-D stated a consultant assisted them with developing their EP. ALD/LPN-D stated they did not know about waiver 1135. ALD/LPN-D stated a designated person to act in the LALD's absence was not in the EP. ALD/LPN-D stated they had a backup supply of food and water, but quantities were not addressed in the EP. ALD/LPN-D stated they thought all of the required content was in their EP. The licensee's Emergency Preparedness Plan policy, undated, indicated, "The agency is committed to maintaining a state of readiness for natural disasters, pandemics, fires, and other emergencies. This policy ensures compliance with applicable state and federal regulations, including MN 4659.0100 and CMS Appendix Z, and outlines procedures for mitigating risks, responding to emergencies, and maintaining continuity of care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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;	0 810		

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0 810	Continued From page 4 (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. (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 interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. 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	0 810		

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0 810	Continued From page 5 or has potential to affect a large portion or all of the residents). The findings include: On December 12, 2024, during interview at approximately 9:45am, assisted living director/licensed practical nurse (ALD/LPN)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: Record review indicated the licensee failed to provide and document adequate procedures for employee actions to be taken in event of a fire. The FSEP failed to identify procedures for staff to take in an emergency. ALD/LPN-D produced a document generally discussing fire prevention and response, but it did not include any staff actions for the facility. FSEP included evidence that staff trainings occurred, but there is not written policy available. During an interview on December 12, 2024, the surveyor explained the requirements for written employee action documents. ALD/LPN-D stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

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01880	Continued From page 6 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for two of two residents (R2, R3) with refrigerated medications. 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 9, 2024, at 10:28 a.m., during the facility tour with assisted living director/licensed practical nurse (ALD/LPN)-D, the surveyor observed the licensee's medication refrigerator which lacked a thermometer to monitor the temperature of the medication refrigerator. ALD/LPN-D stated they were monitoring every other refrigerator in the facility but forgot they needed to monitor the medication refrigerator. ALD/LPN-D stated they did not have temperature logs to provide for the medication refrigerator. ALD/LPN-D stated the medications belonged to R2 and R3, and both residents were currently taking the refrigerated medications. The surveyor observed the contents of the medication refrigerator included the following medications:	01880		

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01880	Continued From page 7 -R2 Basaglar KwikPen; inject 14 units (u) subcutaneously (SQ) every 24 hours for diabetes; one box with five pens; -R2 Humalog KwikPen; 100u per milliliter (ml), inject 4u three times daily and sliding scale before meals; one box with multiple pens; -R2 Lantus SoloStar insulin pen 100u/ml, inject 14u SQ daily; -R2; Ozempic pen, inject 0.75ml (or one milligram (mg)) SQ every week; two boxes with one pen in each box; and -R3; pantoprazole 2mg/ml suspension, take 40mg by mouth (PO) two times a day (KEEP REFRIGERATED); two bottles. On December 10, 2024, at 8:48 a.m., the surveyor observed owner/unlicensed personnel (O/ULP)-B administer pantoprazole 2mg/ml suspension, take 40mg PO two times a day to R3. Manufacturer instructions for Basaglar KwikPen, last revised in November 2023, indicated to store unopened pens between 36-46 degrees Fahrenheit (F) Manufacturer instructions for Lantus, last revised in 2022, indicated store unused Lantus in a refrigerator between 36-46 degrees F; discard if Lantus has been frozen. Manufacturer instructions for Humalog (insulin lispro), last revised on July 2023, indicated to store unused pens in the refrigerator at 36-46 degrees F; do not use if it has been frozen. Manufacturer instructions for Novolog (insulin apart), last revised in February 2023, indicated to store unused pens in the refrigerator at 36-46 degrees F; do not freeze and do not use if it has	01880		

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01880	Continued From page 8 been frozen. Manufacturer instructions for Ozempic, last revised in November 2024, indicated to store new and unused Ozempic pens in the refrigerator between 36-46; do not use if it has been frozen. Manufacturer instructions and packaging for pantoprazole, last reviewed on October 6, 2024, indicated to store final compounded product at refrigerated temperature of 36-46 degrees F. The licensee's Policy on Medication Stored in the Refrigerator, undated, indicated: "2. Temperature Control: o The medication refrigerator must maintain a temperature range of 36°F to 46°F (2°C to 8°C). o Temperature logs shall be maintained and recorded daily to ensure compliance. o Any deviations from the required temperature range must be reported immediately to the supervising nurse or pharmacist." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *12/09/24*
Time: 11:30:00
Report: 1031241360

Food and Beverage Establishment Inspection Report

Location:
EMALINA CARES LLC
2100 55TH AVE N
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:
ID #: 0043828
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Roast Beef
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

Nurse Evaluator on site: Joey Keen

All violations discussed with PIC during the inspection.

NOTES:

- Establishment uses APPROVED Purell sanitizer solution.

- Establishment does not have any food storage (dry or refrigerated) outside of kitchen area.

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Establishment does not have pasteurized eggs and does not prepare eggs for consumption under 145F. Purchase pasteurized eggs if intending to serve eggs undercooked.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

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

I acknowledge receipt of the Environmental Health inspection report number 1031241360 of 12/09/24.

Certified Food Protection Manager: Olusola Segun Olakunde

Certification Number: FM123853 Expires: 06/05/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Olusola Olakunde
Person in Charge

Signed: _____

Chris Foster
Public Health Sanitarian III
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us