Electronically Delivered

February 13, 2024

Licensee
Relief Homecare LLC
700 14th Street
Farmington, MN 55024

RE: Project Number(s) SL35409015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 17, 2024, 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).

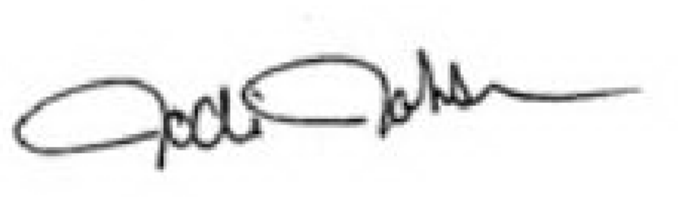
CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and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

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
	35409	A. BUILDING: _____ B. WING _____	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RELIEF HOMECARE LLC	700 14TH STREET FARMINGTON, MN 55024

(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: SL35409015 On January 16, 2024, through January 17, 2024, the Minnesota Department of Health conducted a full 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 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		

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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 January 17, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=F	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks	0 485		

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0 485	Continued From page 2 available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 16, 2024, at 10:30 a.m. during the facility tour, the surveyor did not observe a menu posted. Unlicensed personnel (ULP)-B stated they did not have one posted.	0 485		

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0 485	Continued From page 3 On January 16, 2024, at 1:30 p.m. licensed assisted living director (LALD)-A stated the menus were not posted in the facility, but they usually were and must have been taken down and not put back up. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step TST (tuberculin	0 660		

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0 660	Continued From page 4 skin test) or other evidence of TB screening such as a blood test for one of one unlicensed personnel (ULP-B). This had the potential to affect all residents and staff of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's TB facility risk assessment dated July 1, 2023, indicated they were a low risk level. ULP-B was hired on January 17, 2023, to provide direct care services to residents at the assisted living facility. On January 16, 2024, at 12:30 p.m. ULP-B was observed administering medication and assisting with activities of daily living (ADLs) to R3. ULP-B's employee record contained a tuberculosis risk assessment dated January 21, 2023. ULP-B's employee record contained a negative QuantiFERON TB test dated April 6, 2022. (291 days prior to the date of hire). ULP-B's record lacked evidence of a current TB testing via two-step TST or a blood test. On January 16, 2024, at 1:00 p.m. licensed	0 660		

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0 660	Continued From page 5 assisted living director (LALD)-A stated ULP-B's TB test was completed in 2022 from the previous employer. The licensee's Tuberculosis screening policy dated July 20, 2021, indicated staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. No further information 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	0 680		

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0 680	Continued From page 6 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 an all-hazards risk assessment emergency preparedness (EP) program and plan to include Appendix Z required elements and failed to post emergency exit diagrams in the facility. 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 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: During the entrance conference on January 16, 2024, at 11:00 a.m., the licensee's emergency preparedness plan (EPP) was requested. Licensed assisted living director (LALD)-A stated he was still working on the manual but would provide what he had. In addition, there was no evidence of Exit diagrams posted within the facility at the time of the facility tour. The licensee lacked the following required information according to Emergency Preparedness: Appendix Z:	0 680		

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0 680	Continued From page 7 - a completed risk assessment. - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents. - process for EP cooperation with state and local EP officials/organizations. - arrangements/contracts to re-establish utility services. - procedure for tracking staff and residents. - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems). - evacuation plan which included staff responsibilities during an evacuation and transporting services for residents being evacuated. - shelter in place. - emergency staffing strategies to include volunteers. - the facilities role in providing care and treatment at alternative sites under a 1135 waiver. - LTC Family notification communication plan - Annual emergency prep training and testing review - Emergency prep testing requirements - integrated health systems. On January 16, 2024, at 10:45 a.m. during the engineering tour, LALD-A stated the facility did not have exit diagrams posted and should have. The licensee's Emergency Preparedness Program policies and procedures overview dated September 1, 2023, indicated the Emergency plan will be based on and include a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach.	0 680		

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0 680	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms on each story. This deficient condition had the ability to affect all	0 780		

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0 780	Continued From page 9 staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: On January 16, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed there was no smoke alarm installed in the hallway outside bedrooms #3 and #4 on the main level. During interview on January 16, 2024, at 10:30 a.m., LALD-A stated they understood the requirement for the smoke alarm and would get one installed. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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.	0 800		

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0 800	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 16, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed bedroom #1 downstairs had damage to the door and the wall near the closet. During interview, LALD-A stated the resident in bedroom #1 used a wheelchair and caused the scrape on the door whenever they left or entered the room. Due to the closeness of the wall near the closet, the wheelchair would scrape along the wall too. It was observed the downstairs bathroom and closet for bedroom #4 had burned-out light bulbs. It was observed the doorbell at the main entrance of the house was broken. The edges of the	0 800		

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0 800	Continued From page 11 plastic doorbell were sharp and the electrical wires inside were exposed to the outside. During interview on January 16, 2024, at 10:30 a.m., LALD-A stated he understood the above-listed deficiencies. 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) 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.	0 810		

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0 810	Continued From page 12 (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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observation on January 16, 2024, at 10:30 a.m., the surveyor observed the fire evacuation diagrams were not posted anywhere in the facility. On January 16, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35409	A. BUILDING: _____ B. WING _____	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RELIEF HOMECARE LLC	700 14TH STREET FARMINGTON, MN 55024

(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 The licensee FSEP, titled "9.06 Fire Policy, failed to include the following: 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on January 16, 2024, at 1:00 p.m., LALD-A stated he understood the areas of his policy that were incomplete and would work on bringing them into compliance.	0 810		

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0 810	Continued From page 14 TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. During an interview on January 16, 2024, at 1:00 p.m., LALD-A stated he understood the areas of his training that were insufficient and would work on bringing them into compliance. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evidenced by the fire drill reports provided. Evacuation drills were conducted on 10/18/23 and 11/07/2023. No other documentation was provided. During an interview on January 16, 2024, at 1:00 p.m., LALD-A stated there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility;	01370		

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01370	Continued From page 15 (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed for one of one unlicensed personnel (ULP-B) to include all required content.	01370		

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01370	Continued From page 16 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on January 17, 2023, to provide direct care services to residents at the assisted living facility. On January 16, 2024, at 12:30 p.m. ULP-B was observed administering medication and assisting with activities of daily living (ADLs) to R3. ULP-B's employee record contained the following training documents: - unlicensed personnel competency evaluation form dated January 28, 2023. - Skills assessment form dated December 10, 2023. - Staff in-service training from January 1, 2023, to November 2, 2023. ULP-B's employee record lacked evidence ULP-B had received the following training and competencies: - reports of changes in the resident's condition to the supervisor designated by the facility. On January 16, 2024, at 2:44 p.m. licensed assisted living director (LALD)-A stated ULP-B's file was missing competencies and will look for additional records for ULP-B's employee file.	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01370	Continued From page 17 The licensee's Competency Training Evaluations policy dated July 20, 2021, indicated that prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of one unlicensed personnel (ULP-B).	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01380	Continued From page 18 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-B was hired on January 17, 2023, to provide direct care services to residents at the assisted living facility. ULP-B's employee record contained unlicensed personnel competency evaluation form dated January 28, 2023, which indicated safe transfers, ambulation and positioning were not completed and identified with not-applicable (N/A) mark. ULP-B's employee record lacked evidence ULP-B had received the following training and competency: - safe transfer techniques and ambulation On January 16, 2024, at 2:44 p.m. licensed assisted living director (LALD)-A stated ULP-B's file was missing competencies and will look for additional records for ULP-B's employee file. The licensee's Competency Training Evaluations policy dated July 20, 2021, indicated that prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35409	A. BUILDING: _____ B. WING _____	01/17/2024

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01380	Continued From page 19 (21) days	01380		
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 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 and interview, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel access. This had the potential to affect 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 of the residents). The findings include: On January 16, 2024, at 9:30 a.m. unlicensed personal (ULP)-B and the surveyor entered the locked medication closet and found an unlocked fire box for narcotics. ULP-B stated she unlocked it that morning at shift change and forgot to lock it back up. On January 16, 2024, at 2:00 p.m. licensed assisted living director (LALD)-A stated the	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35409	A. BUILDING: _____ B. WING _____	01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RELIEF HOMECARE LLC	700 14TH STREET FARMINGTON, MN 55024

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01880	Continued From page 20 expectation was the narcotic box was always locked. The licensee's Medications Storage policy dated July 20, 2021, indicated schedule II drugs will be stored under a double lock system and stored separately from other medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	01910		

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01910	Continued From page 21 Based on observation, interview, and record review, the licensee failed to document in the resident's record the disposition of the medications. In addition, the licensee failed to destroy the medication as required for one of one resident (R1) upon discharge. 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 was admitted for services on May 1, 2023, and discharged to family and an undisclosed location on October 28, 2023. R1's diagnoses included major depressive disorder, and anxiety. R1's Mediation list at the time of discharge indicated R1 received the following scheduled medications: Bupropion 300 mg (milligram) (for depression) Certa-vite tab (vitamin supplement) Clonazepam 0.5 mg (used for anxiety) Concerta 36 mg (used for anxiety) Melatonin 3 mg (used for insomnia) Trazadone 50 mg (for insomnia) Hydrocodone-acetaminophen 5-325 mg (for pain) R1's Discharge - Transfer Summary, medication disposition section dated October 28, 2023, noted all medications would be sent with R1's parent.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 22 R1's record lacked a disposition of medications to include: * Prescription number as applicable; and * Quantity On January 16, 2024, at 2:00 p.m. registered nurse (RN)-C stated discontinued medications should be destroyed. On January 17, 2024, at 9:34 a.m. licensed assisted living director (LALD)-A stated the prescription numbers and quantity were not included on the Discharge transfer summary. The licensee's Medication Disposal policy revised July 2021, indicated the facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health

625 Robert St N
St. Paul
55155

Type: Follow-Up
Date: *01/17/24*
Time: 16:55:00
Report: 1043241014

Food and Beverage Establishment Inspection Report

Location:
Relief Homecare Llc
700 14th Street
Farmington, MN55024
Dakota County, 19

Establishment Info:
ID #: 0037754
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072026082
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.

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

Inspection was completed to assess compliance with previous orders. Food thermometer and dish machine test kit (thermolabels) were provided by PIC via email on the same day after the initial food inspection was completed.

Initial inspection was completed on site with F. Akonu. T. Fearon was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

**Foods cooked by the facility staff for clients should be fully cooked and prepared for same day service only with leftovers discarded.

**This facility has a residential kitchen with residential equipment and wooden cabinetry. The kitchen finishes and surfaces are well maintained. Contact Health Regulation Division for plan review when facility undergoes remodeling.

Type: Follow-Up
Date: *01/17/24*
Time: 16:55:00
Report: 1043241014
Relief Homecare Llc

Food and Beverage Establishment Inspection Report

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 1043241014 of 01/17/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Fidelis Akonu
PIC

Signed:_____
Blia Lor
Public Health Sanitarian I
OLF
651-231-7981
blia.lor@state.mn.us

Minnesota Department of Health

625 Robert St N
St. Paul
55155

Type: Full
Date: *01/17/24*
Time: 10:00:00
Report: 1043241011

Food and Beverage Establishment Inspection Report

Location:

Relief Homecare Llc
700 14th Street
Farmington, MN55024
Dakota County, 19

Establishment Info:

ID #: 0037754
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072026082
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS STORED ON SHELF ABOVE READY-TO-EAT FOODS (LETTUCE, CHEESE, CELERY, ETC) IN COOLER. DISCUSSED PROPER STORAGE WITH STAFF. COMPLY WITH ABOVE RULE. STAFF CORRECTED ON SITE.

Comply By: 01/17/24

4-300 Equipment Numbers and Capacities

4-302.12A ***** Priority 2 *****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

STAFF WAS UNABLE TO LOCATE FOOD THERMOMETER AT TIME OF INSPECTION. ADVISED STAFF TO LOCATE AND MAINTAIN, REPURCHASE AS NEEDED. COMPLY WITH ABOVE RULE.

Comply By: 01/17/24

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.

PER STAFF, THERMOLABELS ARE USED FOR THE DISH MACHINE. STAFF WAS UNABLE TO LOCATE LABELS AT TIME OF INSPECTION. ADVISED STAFF TO LOCATE/PROVIDE AND MAINTAIN. UTENSIL SURFACE TEMPERATURE SHOULD BE AT LEAST 160F. COMPLY WITH ABOVE RULE.

Type: Full
Date: *01/17/24*
Time: 10:00:00
Report: 1043241011
Relief Homecare Llc

Food and Beverage Establishment Inspection Report

Comply By: 01/17/24

Food and Equipment Temperatures

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

Process/Item: AMBIENT
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

Discussed date marking, illness policy, sanitizer use, ware washing, temperature control, hand washing, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Inspection was completed with F. Akonu. T. Fearon was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

**Foods cooked by the facility staff for clients should be fully cooked and prepared for same day service only with leftovers discarded.

**This facility has a residential kitchen with residential equipment and wooden cabinetry. The kitchen finishes and surfaces are well maintained. Contact Health Regulation Division for plan review when facility undergoes remodeling.

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 1043241011 of 01/17/24.

Certified Food Protection Manager Emeka E. Anyanwu

Certification Number: FM113864 Expires: 11/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Fidelis Akonu
PIC

Signed: _____
Blia Lor
Public Health Sanitarian I
OLF
651-231-7981
blia.lor@state.mn.us