Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 14, 2024

Licensee
Living Well Home Care LLC
7040 Edgewood Avenue North
Brooklyn Park, MN 55428

RE: Project Number(s) SL40108015

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 May 30, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health note 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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRDAppealsForm**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40108	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL HOME CARE LLC	7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(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 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: SL#40108015 On May 28, 2024, through May 30, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 5 residents; 5 receiving services under the Provisional 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced 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 May 28, 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		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality	0 580		

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0 580	Continued From page 2 management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the licensee and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 28, 2024, at approximately 10:45 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee identified QMP areas, but no meeting minutes, tracking, or specific improvement projects would be documented. The licensee's 2.31 Quality Improvement policy	0 580		

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0 580	Continued From page 3 dated October 17, 2022, indicated a QMP would be implemented, and documentation would be provided upon request. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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	0 630		

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0 630	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the clients). The findings include: R1 was admitted on September 7, 2023. R1's IAPP dated April 13, 2024, indicated R1 was at risk to be abused by another individual, including other vulnerable adults and did not include statements of specific measures to be taken to minimize the risk of abuse to R1 from others. On May 28, 2024, at 12:45 p.m., licensed assisted living director LALD-A acknowledged R1's IAPP did not include statements of specific measures to be taken to minimize risks. LALD-A also stated was not aware of all the required contents of the IAPP. The licensee's Vulnerable Adult policy dated October 17, 2022, indicated the licensee developed individualized vulnerable adult abuse prevention plans to identify risks and develop measures to minimize maltreatment based on identified information. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640		

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0 640	Continued From page 5 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content to include the 911 emergency number in common areas. 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) 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 May 28, 2024, at 9:30 a.m., during the facility tour, the surveyor observed the main areas of the facility with unlicensed personnel (ULP)-C. The surveyor did not observe the 911 emergency number posted near two cordless telephones located in the main level kitchen. On May 28, 2024, at 9:35 a.m., ULP-C stated the cordless telephones could be used by staff, residents, or visitors.	0 640		

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0 640	Continued From page 6 On May 28, 2024, at 11:30 a.m., licensed assisted living director (LALD)-A stated was unaware of the requirement for the 911 emergency number to be posted near the cordless telephones in the common areas. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional	0 680		

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0 680	Continued From page 7 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, 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 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 of the residents). The findings include: On May 28, 2024, at approximately 10:30 a.m., agent (A)-D arrived at the facility with a binder that was stored at the licensee's offsite office and stated the contents were the licensee's EPP. The licensee's EPP undated, lacked an individualized plan to include all the required content below: - facility's Hazard Vulnerability Analysis (HVA); -missing annual review; -missing resident quarterly review; -description of the population served by licensee; -process for EP cooperation with state and local EP officials/organizations; -development of all policies/procedures (P/P) based on HVA assessment; -development of a communication plan; and -EP training and testing program.	0 680		

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0 680	Continued From page 8 On May 28, 2024, at approximately 2:30 p.m., licensed assisted living director (LALD)-A acknowledged the licensee's EPP lacked the above listed required content. LALD-A stated the licensee's EPP was a work in progress and was not aware of all the requirements of Appendix Z. The licensee's Emergency Preparedness policy dated August 24, 2023, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services and the EPP would be prominently posted on each floor of the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	0 790		

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0 790	Continued From page 9 by: Based on observation and interview, the licensee failed to provide documentation of monthly inspections of all the fire extinguishers. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On May 28, 2024, survey staff conducted a facility tour with licensed assisted living director (LALD)-A, survey staff observed that the fire extinguishers throughout the facility did not have documentation of monthly inspections. Monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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;	0 810		

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0 810	Continued From page 10 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This 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	0 810		

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0 810	Continued From page 11 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 May 30, 2024, at 2:14 p.m., licensed assisted living director (LALD)-A provided documents via email on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency as well as complete procedures for residents' movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The current plan needs to be updated to the facilities current setup as it had details on an automatic dialer that will notify the alarm monitoring company and a fire panel annunciator panel which this facility is not equipped with this type of fire alarm system. Record review of the available documentation indicated that the licensee did not provide training for employees on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Record review of the available documentation indicated that the licensee did not conduct	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40108	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL HOME CARE LLC	7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

(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 12 evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed one evacuation drill in May 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=D	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 an employee 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 interview and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) number for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01290		

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	40108	A. BUILDING: _____ B. WING _____	05/30/2024

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01290	Continued From page 13 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-C was hired on March 1, 2020. ULP-C's employee record included a BGS clearance dated August 10, 2021, affiliated with another licensee's HFID 37939 (owned by the same owner). ULP-C's employee record lacked evidence of current, cleared BGS affiliated with the licensee's assisted living HFID 40108. On May 28, 2024, at approximately 11:10 a.m., the Minnesota Department of Human Services NETStudy2 website indicated ULP-C's BGS was not affiliated with HFID 40108. On May 28, 2024, at approximately 11:30 a.m., licensed assisted living assisted director (LALD)-A stated the BGS for ULP-C is under a license of a different facility the licensee's owner owns, and ULP-C was not affiliated with HFID 40108 and was not sure why. The licensee's Recruitment and Hiring policy dated October 17, 2022, indicated the licensee complies with all state regulations for pre-employment background checks/studies required for all employees. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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	40108	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING WELL HOME CARE LLC	7040 EDGEWOOD AVENUE NORTH BROOKLYN PARK, MN 55428

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02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R2) who utilized hospital side rails. 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: On May 28, 2024, at approximately 09:30 a.m., during facility tour, the surveyor observed a hospital style bed with raised bilateral (both sides of the bed) upper half side rails on R2's occupied hospital bed. R2 was admitted to the licensee on January 16, 2024. R2's registered nurse (RN) assessment dated April 1, 2024, indicated R2's bilateral side rail safety zones assessment was not applicable and	02310		

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	40108	A. BUILDING: _____ B. WING _____	05/30/2024

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02310	Continued From page 15 met FDA guidelines. R2's assessment lacked documentation of R2's side rail measurements for safety zones one through four and within the parameters of Food and Drug Administration's (FDA) guidelines. On May 28, 2024, at 1:30 p.m., licensed assisted living director (LALD)-A stated there were no actual measurements for R2's side rails that could be found and was unsure why R2's side rail measurements were not completed. The licensee's Side Rail Use policy dated October 17, 2022, indicated documentation regarding side rails will include the measurements and inspecting the side rails for any functional problems or maintenance issues. The FDA A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40108	A. BUILDING: _____ B. WING _____	05/30/2024

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03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not 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 May 28, 2024, at 9:15 a.m., upon entering the facility, the surveyor observed two entrances accessible by visitors to the facility and lacked the required notice for electronic monitoring. On May 28, 2024, at approximately 09:30 a.m., during a facility tour, multiple cameras were noted throughout the facility.	03090		

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03090	Continued From page 17 On May 28, 2024, at 11:30 a.m., licensed assisted living director (LALD)-A stated the licensee was not aware of the required verbatim notice to be posted at the entrances accessible by visitors. LALD-A also stated the required electronic monitoring posting would need to be placed at the entrances. The licensee's Electronic Monitoring policy dated October 17, 2022, indicated the licensee would post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *05/28/24*
Time: 11:00:25
Report: 1051241019

Food and Beverage Establishment Inspection Report

Location:
Living Well Home Care LLC
7040 Edgewood Ave N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:
ID #: 0042673
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #: 7633001577
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

AMBIENT TEMPERATURE IN KITCHEN UPRIGHT COOLER READ 50F. ADJUST UNIT COLDER OR MOVE TCS ITEMS TO BASEMENT UPRIGHT COOLER.

Comply By: 05/28/24

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

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

AT TIME ON INSPECTION, THERE WERE NO TEST STRIPS TO TEST THE SANITIZER IN THE DISHMACHINE.

Comply By: 05/28/24

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 50 Degrees Fahrenheit - Location: AMBIENT--KITCHEN
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: AMBIENT-BASEMENT
Violation Issued: No

Type: Full
Date: *05/28/24*
Time: 11:00:25
Report: 1051241019
Living Well Home Care LLC

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: SLICED CHEESE--KITCHEN
Violation Issued: No

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

THE FACILITY WAS INSPECTED BY KAI YANG (MDH).

MET UP WITH NURSE SURVEYOR, CARL SAMROCK.

DISCUSSED THE FOLLOWING WITH SELEKIE (MANAGER) AND KUMBA (KITCHEN STAFF):

EMPLOYEE ILLNESS LOG (EMAILED WITH REPORT)
VOMIT CLEAN-UP PROCEDURE (EMAILED WITH REPORT)

THE KITCHEN HAS A NSF 184 DISHWASHER, WOODEN MDF CABINETS, WOODEN FLOOR, SMOOTH CEILING, AND LAMINATE COUNTERTOPS.

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 1051241019 of 05/28/24.

Certified Food Protection Manager: Selekie Kamara

Certification Number: FM113625 Expires: 11/04/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Selekie Kamara

Signed: _____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us