Electronically Delivered

July 30, 2024

Licensee
Reliacare Home Health Inc.
680 Thomas Avenue
Saint Paul, MN 55104

RE: Project Number(s) SL33532015

Dear Licensee:

On July 8, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 25, 2024, survey and the April 16, 2024 follow-up survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

May 3, 2024

Licensee
Reliacare Home Health Inc.
680 Thomas Avenue
Saint Paul, MN 55104

RE: Project Number(s) SL33532015

Dear Licensee:

On April 16, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 25, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 25, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 25, 2024, found not corrected at the time of the April 16, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0800 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (4) - $500.00

The details of the violations noted at the time of this follow-up survey completed on April 16, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on April 16, 2024, we identified the following violation(s):

1620 - Initial Reviews, Assessments, And Monitoring - 144g.70 Subd. 2 (c-E)

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

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.

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 the Department of Health 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.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33532	A. BUILDING: _____ B. WING _____	R 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RELIACARE HOME HEALTH INC	680 THOMAS AVENUE SAINT PAUL, MN 55104

(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 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL33532015-1 On April 15, 2024, through April 16, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 25, 2024. At the time of the survey, there were two (2) residents receiving services under the provider's 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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: No further action required.	{0 480}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	{0 800}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 800}	Continued From page 2 a large portion or all of the residents). Findings include: On a facility tour on April 15, 2024, at 12:30 p.m., with housing manager (HM)-C, the surveyor made the following observations of facility hazards and disrepair: Maintenance The bottom step measures 9 ¾ inches on the left side and 10 ½ inches on the right side, at the exterior steps/ landing for the front main exit/entry door. The remainder of the steps in the stairway measure 6 ¾ inches. The bottom step is required to be equal to the remainder of the steps in the stairway in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511. During an interview on April 15, 2024, at 12:40 p.m., HM-C, stated the bottom step in the stairway was higher than the others because of ground settling of the sidewalk in front of the step and they are currently working on the repair and waiting for the concrete contractor they have hired.	{0 800}		
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 820}	Continued From page 3 be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. 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). Findings include: On a facility tour on April 15, 2024, at 12:45 p.m., with housing manager (HM)-C, it was observed that the newly replaced existing emergency escape and rescue opening window did not meet the minimum requirements for clear opening width in resident sleeping room number 4 occupied by R3. Occupied At the time of survey entry, the newly replaced existing emergency escape and rescue window in resident room number 4 occupied by R3, measured 17 inches wide, 47 inches high and 799 square inches clear opening area. While	{0 820}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{0 820}	Continued From page 4 survey staff was on site HM-C, moved R3 from resident sleeping room number 4 into resident room number 5 which had an existing emergency escape and rescue opening measuring 28 inches wide, 27 inches high and 756 square inches of clear opening area. The emergency escape and rescue window in resident sleeping room number 4 did not meet the minimum requirements for clear opening width. During an interview on April 15, 2024, 1:15 p.m., HM-C, stated R3 will not be moved back into resident sleeping room number 4 until a compliant emergency escape and rescue window is installed and approved. During the same interview HM-C, stated the window supplier for the replacement window stated the window met minimum size requirements for egress. On April 16, 2024, at 3:56 p.m., licensed assisted living director (LALD)-D, provided email documentation R3 will not occupy resident sleeping room number 4 until a compliant emergency escape and rescue window is installed and approved.	{0 820}		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 5 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed a comprehensive reassessment to include all required content identified per Minnesota (MN) Administrative Rule 4659.0150 Uniform Assessment Tool for two of two residents (R1, R3). 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: R1 and R3 were admitted on March 8, 2023, and July 29, 2021, respectively. R1's Nurse Reassessment Visit dated December 26, 2023, was a two (2) page document identified	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 6 by licensed assisted living director (LALD)-D as R1's most recent reassessment. The document had markings next to, "NC," which indicated "No Change," and was signed as completed by a RN. R3's Nurse Reassessment Visit dated March 22, 2024, was a two (2) page document identified by LALD-D as R3's most recent reassessment. The document had markings next to, "NC," which indicated "No Change," and was signed as completed by a RN. R1 and R3's reassessments lacked content identified by MN Administrative Rule 4659.0150 Uniform Assessment Tool in Subpart 2, Section A through Section O to be completed with each assessment and reassessment. On April 16, 2024, at 1:15 p.m., LALD-D stated licensee used the same reassessment form for all resident reassessments. LALD-D stated licensee was not aware of the requirements in Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool and licensee had not implemented reassessments with all required content. LALD-D stated licensee had used the form from a previously held license but had failed to update the assessment content when the assisted living license was obtained. The licensee's Assessment and Reassessment policy dated December 20, 2022, referenced MN Statute 144G.70, Subd. 2 and 5; MN Rules 4659.0140 but failed to reference the content of assessments and reassessments per the MN Administrative Rule 4659.0150 Uniform Assessment Tool. No further information provided.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01620	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 15, 2024

Licensee
Reliacare Home Health Inc.
680 Thomas Avenue
Saint Paul, MN 55104

RE: Project Number(s) SL33532015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 25, 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.

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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.

MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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 the Department of Health 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.

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33532	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: SL33532015-0 On January 22, 2024, through January 25, 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 (4) residents receiving services under the Assisted Living license. The immediacy of order 0830 was lifted on January 24, 2024. The scope and level remain unchanged.	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33532	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RELIACARE HOME HEALTH INC	680 THOMAS AVENUE SAINT PAUL, MN 55104

(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
0 480	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 23, 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		
0 630 SS=D	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	0 630		

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0 630	Continued From page 2 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 observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 23, 2024, at 10:32 a.m., surveyor observed unlicensed personnel (ULP)-B provide a medication reminder to R1. R1's diagnoses included schizophrenia and substance use disorder. R1's IAPP signed March 8, 2023, identified R1 was vulnerable to self-abuse by engaging in self-injurious behaviors and inability to care for	0 630		

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0 630	Continued From page 3 self-help needs. The IAPP lacked specific measures to minimize risk of abuse related to smoking. On January 23, 2024, at 10:34 a.m. ULP-B stated residents went outside to smoke either at the front of the house or the back of the house. ULP-B stated R1 has been 'called out' on smoking in his room in the past by other staff, but she had never come across him smoking in his room. ULP-B stated she believed R1 smoked marijuana but was not aware if he smoked cigarettes. On January 23, 2024, 11:15 a.m. housing manager (HM)-C stated he was aware of R1 smoking in his room and didn't know what more he could do. HM-C stated R1 was working with a mental health therapist and had placed interventions such as education and taking away activities if R1 was found to be smoking in his room. HM-C also indicated they posted, "no smoking" signs within the home. On January 23, 2024, at 11:41 p.m. licensed assisted living director (LALD)-D stated staff would begin daily checks on R1 to make sure he was not smoking. LALD-D stated R1 was working on this issue with the mental health therapist. LALD-D stated they did not have documentation of R1's smoking incidents but had spoken with the county case manager and the mental health therapist about the issue. On January 24, 2024, at 11:49 a.m., surveyor received an updated IAPP to include measures to reduce risk of smoking inside the facility. The licensee's Vulnerable Adult policy effective August 1, 2021, indicated the IAPP would be	0 630		

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0 630	Continued From page 4 implemented immediately upon admission and evaluated at each supervisory visit or more frequently, if necessary. The policy also indicated documentation would include results of the implementation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced	0 650		

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0 650	Continued From page 5 by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of one employee (unlicensed personnel (ULP)-B). 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 January 23, 2024, 10:32 a.m., ULP-B provided medication reminders to all residents. ULP-B was hired March 10, 2021, to provide direct cares and services to residents. ULP-B's record lacked documentation of training of ULP providing assisted living services, under Minnesota Statue, chapter 144.G.61, subdivision 2 (a) and (b) to include the following: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; and -dressing and assisting with toileting;	0 650		

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0 650	Continued From page 6 -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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; -awareness of confidentiality and privacy; -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. On January 23, 2024, at 10:33 a.m., ULP-B stated she did a mix of training to include in-person training with a registered nurse (RN) and online training. ULP-B could not remember the content of training received but stated she knew what to do when it came to resident cares. On January 23, 2024, at 2:36 p.m., licensed assisted living director (LALD)-D stated she could not provide documentation of the above required training. LALD-D stated the RN trained her on the above requirements. LALD-D also stated this	0 650		

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0 650	Continued From page 7 documentation was missing for all ULPs' records, and said she would update the form to include the missing documentation. The licensee's Personnel Records policy effective August 1, 2021, indicated documentation of orientation would be kept in the personnel file for each paid employee providing assisted living services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 680		

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0 680	Continued From page 8 allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview, 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 January 22, 2024, at approximately 12:30 p.m., licensed assisted living director (LALD)-D provided a binder and indicated the contents were the licensee's EPP. The licensee's EPP established on August 1, 2021, lacked documentation to include all the required elements of: -annual review; -missing resident quarterly review; -policies and procedures for volunteers; and -emergency prep testing requirements. On January 24, 2024, 12:20 p.m., LALD-D stated she met with her consultant to go over policies	0 680		

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0 680	Continued From page 9 including the missing resident policy. LALD-D was unable to provide documentation that the missing resident policy was reviewed quarterly or that the EPP was reviewed annually. LALD-D stated she made changes to include a new clinical nurse supervisor. LALD-D stated her consultant did not have policies or procedures for volunteers. LALD-D acknowledged she did not meet the emergency prep testing requirements. The licensee's Emergency Preparedness policy effective August 1, 2021, indicated the EPP would be reviewed/updated at least annually. The licensee's 1.4 Emergency Plan dated 2021, indicated exercises were conducted at least annually to test the emergency plan, including unannounced staff drills using emergency procedures. The plan also indicated the licensee would participate in one full-scale exercise that is either community based or facility-based exercise. The licensee's Missing Resident policy with effective August 1, 2021, indicated the missing resident procedure would be reviewed by the director and clinical nurse supervisor at least quarterly and any changes would be documented. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's	0 730		

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0 730	Continued From page 10 name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation,	0 730		

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0 730	Continued From page 11 when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document incidents and action plans when identified for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During entrance conference on January 22, 2024, at approximately 12:45 p.m., surveyor requested documentation of incidents and/or accidents for the past six (6) months. Licensed assisted living director (LALD)-D stated there were no incident reports to provide. During interview on January 23, 2024, at 10:32 a.m., unlicensed personnel (ULP)-B indicated staff had called R1 out on smoking marijuana in his room, but ULP-B was unsure if R1 smoked cigarettes. ULP-B stated she had not come across R1 smoking in his room. On January 23, 2024, at 11:14 a.m., the surveyor and housing manager (HM)-C entered R1's	0 730		

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0 730	Continued From page 12 bedroom on the second level and the surveyor noted a strong smell of marijuana. The surveyor then noted a glass-round ashtray sitting on R1's dresser with ashes inside. Next to the ashtray was a used cigarette butt. There were ashes on the floor in front of the dresser. There was a lighter located on R1's bed, and between the bedroom door and dresser, was a fabric chair. The surveyor noted a smoke detector and its battery taken out and sitting next to it on that fabric chair. The smoke detector was taken off the wall above the bedroom door. Above the fabric chair, was what appeared to be a small glass bong (typically used for cannabis, tobacco, or other herbal substances) on the wall shelf. R1 was admitted on March 8, 2023, with diagnoses of schizophrenia and substance use disorder. R1's Home Health Aide Care Plan signed on March 9, 2023, indicated R1 required queuing to initiate dressing and grooming, encouragement to eat appropriate and healthy meals, behavior management, medication reminders, housekeeping, and laundry. On January 23, 2024, 11:15 a.m., HM-C stated he was aware of R1 smoking in his room and didn't know what more he could do. HM-C stated R1 was working with a mental health therapist and had placed interventions such as education and taking away activities if R1 was found to be smoking in his room. HM-C also indicated they posted "no smoking" signs within the home. On January 23, 2024, at 11:41 p.m., LALD-D stated staff would begin daily checks on R1 to make sure he was not smoking. LALD-D stated R1 was working on this issue with the mental	0 730		

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0 730	Continued From page 13 health therapist. LALD-D stated they did not have documentation of R1's smoking incidents but had spoken with the county case manager and the mental health therapist about the issue. On January 23, 2024, at 12:18 p.m., clinical nurse supervisor (CNS)-A stated she was not made aware of any incidents of R1 smoking in his room. The licensee's Clinical Records policy effective August 1, 2021, indicated all resident's clinical record should include documentation of incidents and/or significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health professional. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical	0 800		

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0 800	Continued From page 14 environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 a facility tour on January 24, 2024, at 2:15 p.m., with housing manager (HM)-C, the surveyor made the following observations of facility hazards and disrepair: Smoking Materials Cigarette butts were observed on the ground around the back door aluminum ramp landing and on the ground at the front door stairway and landing. There was not an appropriate container for dispensing of the used cigarette butts near the front or back door but there was a plastic bucket in the back yard near the picnic table. An appropriate (metal or listed container) used cigarette butt disposal container is required to be provided at the designated facility smoking area. Smoking activities are required to comply with the facility smoking policy. During an interview on January 24, 2024, at 2:45 p.m., HM-C, stated the designated smoking area	0 800		

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0 800	Continued From page 15 for the facility was the picnic table in the back yard and there was not an appropriated dispenser provided for dispensing used smoking materials at that location. Maintenance The bottom step measures 9 ¾ inches on the left side and 10 ½ inches on the right side, at the exterior steps/ landing for the front main exit/entry door. The remainder of the steps in the stairway measure 6 ¾ inches. The bottom step is required to be equal to the remainder of the steps in the stairway in accordance with Minnesota Fire Code in Minnesota Rules Chapter 7511. During an interview on January 24, 2024, at 3:00 p.m., HM-C, stated the bottom step in the stairway was higher than the others because of ground settling of the sidewalk in front of the step and they will raise the sidewalk so the bottom step is equal to the remainder of the steps in the stairway. 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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33532	A. BUILDING: _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 16 (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 observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 17 or has potential to affect a large portion or all of the residents). The findings include: On January 25, 2024, at 10:00 a.m., licensed assisted living director (LALD)-D, 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 The licensee FSEP dated December 20, 2022, failed to include the following: The location of resident sleeping rooms number 1 occupied by R2, and resident sleeping room number 2 occupied by R4, on the main floor. The posted floor plan in the facility indicated room number 1 and 2 in opposite locations than the floor plan of the building and what is labeled on the door of the rooms. The resident room occupied by R4 did not have a number on the door. The FSEP floor plan is required to be accurate to the floor plan of the building and all resident sleeping room doors are required to be labeled in order to provide occupants direction for evacuation in the event of a fire or similar emergency. The FSEP did not identify specific fire protection actions for residents evident by not providing these specific procedures for the residents in writing in the FSEP. The fire protection procedures/ actions provided in the plan were directed toward the employees. The FSEP included standard resident evacuation procedures, but failed to provide specific	0 810		

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0 810	Continued From page 18 procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan failed to include individual unique and unusual needs for evacuation for each resident in the FSEP and available for use during a fire or similar emergency. During an interview on January 25, 2024, at 10:15 a.m., LALD-D stated the plan did not include in writing, resident actions required or each residents unique and unusual needs for evacuation in the event of a fire or similar emergency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 820		

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0 820	Continued From page 19 failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff. 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). Findings include: On a facility tour on January 24, 2024, at 2:15 p.m., with housing manager (HM)-C, it was observed that the existing emergency escape and rescue opening windows did not meet the minimum requirements for clear opening square inch area, in resident sleeping room number 1 occupied by R2, resident sleeping room number 3 occupied by R1, and resident sleeping room number 4 occupied by R3. The existing emergency escape and rescue openings also did not meet the minimum clear opening square inch area in unoccupied resident rooms number 5 and 7. Occupied At the time of survey entry, the existing emergency escape and rescue window in resident room number 1 occupied by R2, measured 23 ¾ inches wide, 21 inches high and 499 square inches clear opening area. While survey staff was on site HM-C, replaced the window in resident room number 1 with an emergency escape and rescue window with a clear opening of 23 inches wide, 41 inches high	0 820		

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0 820	Continued From page 20 and clear opening area 943 square inches. The emergency escape and rescue window in resident sleeping room number 1 did not meet the minimum requirements for clear opening area. At the time of survey entry, the existing emergency escape and rescue window in resident room number 3 occupied by R1, measured 22 inches wide, 23 3/4 inches high and 523 square inches clear opening area. While survey staff was on site HM-C, replaced the window in resident room number 3 with an emergency escape and rescue window with a clear opening of 20 inches wide, 47 inches high and clear opening area 940 square inches. The emergency escape and rescue window in resident sleeping room number 3 did not meet the minimum requirements for clear opening area. At the time of survey entry, the existing emergency escape and rescue window in resident room number 4 occupied by R3, measured 23 inches wide, 25 inches high and 575 square inches clear opening area. While survey staff was on site HM-C, moved R3 from resident sleeping room number 4 into resident room number 6 which had an existing emergency escape and rescue opening measuring 28 inches wide, 27 inches high and 756 square inches of clear opening area. The emergency escape and rescue window in resident sleeping room number 4 did not meet the minimum requirements for clear opening area. Unoccupied Emergency escape and rescue windows in resident sleeping room number 5 and resident	0 820		

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0 820	Continued From page 21 sleeping room number 7 measured 23 inches wide, 24 inches high and 552 square inches clear area. The emergency escape and rescue windows in residents sleeping rooms number 5 and 7 did not meet the minimum requirements for clear opening area. These deficient conditions were visually verified by HM-C accompanying on the tour. During an interview on January 24, 2024, at 2:45 p.m., HM-C, stated R3 will not be moved back into resident sleeping room number 4 until a compliant emergency escape and rescue window is installed. During the same interview HM-C also stated the emergency escape and rescue windows will be replaced with compliant windows in unoccupied resident sleeping rooms number 5 and number 7. On January 25, 2024, at 1:45 p.m., licensed assisted living director (LALD)-D, provided email documentation a building permit will be obtained for the window replacements and R3 will not occupy resident sleeping room number 4 until a compliant emergency escape and rescue window is installed. TIME PERIOD FOR CORRECTION: two (2) days	0 820		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 830		

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0 830	Continued From page 22 review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R1). This resulted in an immediate correction order on January 23, 2024. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 the potential to affect a large portion or all of the residents). The findings include: On January 23, 2024, at 11:14 a.m., the surveyor and housing manager (HM)-C entered R1's bedroom on the second level and the surveyor noted a strong smell of marijuana. The surveyor then noted a glass-round ashtray sitting on R1's dresser with ashes inside. Next to the ashtray was a used cigarette butt. There were ashes on the floor in front of the dresser. There was a lighter located on R1's bed, and between the bedroom door and dresser, was a fabric chair. The surveyor noted a smoke detector and it's battery taken out and sitting next to it on the fabric chair. The smoke detector was taken off the wall above the bedroom door. Above the fabric chair, was what appeared to be a small glass bong (typically used for cannabis, tobacco, or other herbal substances) on the wall shelf. R1 was admitted to the facility on March 8, 2023, and resided on the upper level of the facility. R1's diagnoses included schizophrenia and	0 830		

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0 830	Continued From page 23 substance use disorder. R1's Resident Evaluation dated March 9, 2023, indicated R1 was a smoker for three years. Under "Safety Factors with Smoking," it was left blank. R1's Exhibit 2: Service Plan signed on March 8, 2023, indicated R1 was not a smoker. On January 23, 2024, at 10:34 a.m., unlicensed personnel (ULP)-B stated residents went outside to smoke either at the front of the house or the back of the house. ULP-B stated R1 has been 'called out' on smoking in his room in the past by other staff, but she had never come across him smoking in his room. ULP-B stated she believed R1 smoked marijuana, but was not aware if he smoked cigarettes. On January 23, 2024, 11:15 a.m. HM-C stated he was aware of R1 smoking in his room and didn't know what more he could do. HM-C stated R1 was working with a mental health therapist and had placed interventions such as education and taking away activities if R1 was found to be smoking in his room. HM-C also indicated they posted, "no smoking" signs within the home. On January 23, 2024, at 11:41 p.m., licensed assisted living director (LALD)-D stated staff would begin daily checks on R1 to make sure he was not smoking. LALD-D stated R1 was working on this issue with the mental health therapist. LALD-D stated they did not have documentation of R1's smoking incidents but had spoken with the county case manager and the mental health therapist about the issue. On January 23, 2024, at 12:18 p.m., clinical nurse supervisor (CNS)-A stated she was not made	0 830		

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0 830	Continued From page 24 aware of any smoking incidents with R1. CNS-A stated she had, "not heard that, but not surprised." CNS-A stated during the most recent registered nurse assessment, she asked R1 if he smoked and R1 told her no. CNS-A also stated at the time of the assessment, staff did not report any smoking incidents to her. The licensee's Assisted Living Contract signed on March 8, 2023, indicated on page five, no smoking was allowed in the licensee's facility. The licensee's 4.59 Smoking/Tobacco Use policy effective July 31, 2021, indicated, "Residents and Employees are prohibited from smoking, using tobacco in any other form, or using e-cigarettes." The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited in health care facilities and clinics. In addition, an indoor area meant a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (opened or closed) around the perimeter. A wall included retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics: (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state	0 830		

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0 830	Continued From page 25 and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The immediacy of order 0830 was lifted on January 24, 2024. The scope and level remain unchanged.	0 830		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01530		

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01530	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-B) received the required amount of dementia care training in the required time frame. 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: ULP-B was hired March 10, 2021, to provide direct cares and services to residents. On January 23, 2024, 10:32 a.m., ULP-B provided medication reminders to all residents. ULP-B's record included: -Orientation Checklist: "Dementia (4 hours required within 80 hours for direct caregivers," on July 24, 2021; -Certificate of Completion-one hour of dementia training on March 19, 2022; -same certificate as above but a number "2" written over number "1" for dementia training on March 29, 2023. ULP-B's employee record did not include a total of eight hours of the required dementia training completed within 160 hours of the employee's	01530		

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01530	Continued From page 27 start date and a total of two hours of the required dementia training annually. On January 23, 2024, at 2:06 p.m., surveyor asked assisted living director (LALD)-D if they provided all staff with four (4) hours of dementia training and she stated yes, and that the registered nurse (RN) provided the training, but she wanted to check with Home Care Consultants (provided consulting services) because they received the training information from them. On January 23, 2024, at 2:36 p.m., LALD-D stated she understood the dementia training requirement was eight hours initially and four hours annually. LALD-D stated all staff training records have the same documentation. On January 23, 2024, at 2:38 p.m., LALD-D provided surveyor with dementia training they use for their staff titled "Dementia Part 1: An overview." At the end of this document, included a blank certificate indicating this training provided one hour of dementia training. The licensee's Dementia Education policy effective August 1, 2021, indicated direct care employees would provide eight hours of initial dementia training and two hours of education on topics related to dementia for each 12 months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/23/24*
Time: 11:11:50
Report: 1021241022

Food and Beverage Establishment Inspection Report

Location:
Reliacare Home Health Inc
680 Thomas Avenue
St Paul, MN55104
Ramsey County, 62

Establishment Info:
ID #: 0037677
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6123661381
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.

4-700 Sanitizing Equipment and Utensils

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

ESTABLISHMENT DOES NOT HAVE A THREE COMPARTMENT SINK OR DISH MACHINE. ALL DISHES AND UTENSILS NEED TO BE CLEANED AND SANITIZED. IN THE MEANTIME STAFF ARE WASHING AND RINSING IN THE TWO COMPARTMENT SINK AND THEY ARE USING A CONTAINER TO SANITIZE. SEE COMM

Comply By: 01/23/24

7-200 Toxic Supplies and Applications

7-204.11 ***** Priority 1 *****

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

BLEACH FOUND ON-SITE IS SPLASH-LESS AND SCENTED. IT IS ONLY FOR LAUNDRY AND BATHROOM USE. THE LABEL DOES NOT MENTION THAT IT CAN BE USED FOR FOOD CONTACT SURFACES. DISCUSSED WITH STAFF THE APPROVED SANITIZING SOLUTIONS. STAFF WILL GET APPROVED SANITIZER.

Comply By: 01/23/24

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.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF BLEACH. PROVIDE.

Comply By: 01/30/24

Type: Full
Date: *01/23/24*
Time: 11:11:50
Report: 1021241022
Reliacare Home Health Inc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: MILK - REFRIGERATOR
Violation Issued: No

Process/Item: Thawing
Temperature: 25 Degrees Fahrenheit - Location: RAW GROUND BEEF - REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH DIRECTOR, LORI YOUMANS AND HEALTH REGULATION DIVISION NURSE EVALUATOR, ANNA BOHNEN.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 4 CLIENTS AND THE FACILITY CAN HAVE UP TO 5 CLIENTS.

PER CONVERSATION WITH STAFF, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.0900
THE BUCKET FOR SANITIZING IS ONLY A TEMPORARY SOLUTION. ESTABLISHMENT NEEDS TO GET A DISH MACHINE. THE DISH MACHINE NEEDS TO MEET THE NSF/ANSI 184 STANDARD. HANDOUT SENT WITH REPORT.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, LAMINATE COUNTERTOPS AND PAINTED DRYWALL. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

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 1021241022 of 01/23/24.

Certified Food Protection Manager: DAVID E. YOUMANS

Certification Number: FM109334 Expires: 10/15/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
LORI YOUMANS
DIRECTOR

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495

Food and Beverage Establishment Inspection Report

Melissa.Ramos@state.mn.us