DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

July 1, 2022

Administrator
2 Caring Hands Inc
18712 Euclid Path
Farmington, MN 55024

RE: Project Number SL31747015

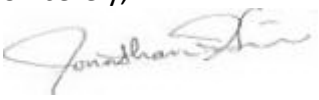
Dear Administrator:

On June 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the March 17, 2022, evaluation were corrected. This follow-up evaluation verified that the facility in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-592-5119 Fax: 651-215-9697

HHH

Electronically Delivered

May 6, 2022

Administrator
2 Caring Hands, Inc.
18712 Euclid Path
Farmington, MN 55024

RE: Project Number(s) SL31747015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 17, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 licensing 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. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31747	A. BUILDING: _____ B. WING _____	03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
2 CARING HANDS INC	18712 EUCLID PATH FARMINGTON, MN 55024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL31747015 On March 15, 2022, through March 17, 2022, 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 six (6) residents, all of whom received services under the provider's Assisted Living license. On March 15, 2022, an immediate correction order was issued at 2310. The immediacy of the correction order, tag identification 2310 was removed March 16, 2022.	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		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 included document titled, Food and Beverage Establishment Inspection Report dated March 16, 2022, for the specific Minnesota	0 480		

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0 480	Continued From page 2 Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This had the potential to affect all six (6) residents receiving assisted living services, staff, and visitors of the facility.	0 550		

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0 550	Continued From page 3 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 March 15, 2022, at 3:50 p.m., observations of the facility revealed the licensee lacked a posting of the above required content. On March 15, 2022, at 4:30 p.m., owner (O)-A confirmed the required content noted above had not been posted in the facility as required. A policy was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 550		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that	0 660		

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0 660	Continued From page 4 covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a TB risk assessment for the facility and ensure history and symptoms screening and screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for two of two employees (unlicensed personnel (ULP)-B, ULP-C) with employee records reviewed. This had the potential to affect all ninety (90) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference with owner (O)-A on March 15, 2022, at approximately 10:45 a.m. the facility's TB risk assessment was requested.	0 660		

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0 660	Continued From page 5 O-A stated a facility TB risk assessment had not been completed for this location. The records of ULP-B and ULP-C lacked evidence of: a current completed health history and TB symptom screening; a two-step TST, or other evidence of TB screening, such as a blood test. ULP-B and ULP-C's employee records indicated a start date of June 1, 2021, and November 20, 2021, respectively. The employee records lacked: - current documentation of a completed health history and symptom screening; - completion of a two-step TST or other evidence of TB screening such as a blood test upon hire. On March 16, 2022, at approximately 12:45 p.m. O-A stated she was not aware a current health history and symptom screening was required for employees upon hire and annually; a two-step TST was required, or other evidence of TB screening, such as a blood test was required. O-A confirmed ULP-B and ULP-C had not completed the TB history and symptom screening or two-step TST or blood test prior to starting employment. A policy was requested, but not provided. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test)	0 660		

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0 660	Continued From page 6 or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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 record review and interview, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all six residents receiving assisted living services, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 16, 2022, at approximately 11:00 a.m. the emergency preparedness plan was requested during the entrance conference. At approximately 1:00 p.m. owner (O)-A stated work was not completed on the licensee's emergency preparedness plan and Appendix Z. The licensee's plan lacked the following required content: -current, all-hazards approach facility assessment -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations. -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents' -development of all policies/procedures, based on	0 680		

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0 680	Continued From page 8 assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -development of a communication plan, including primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); -annual EP testing requirements. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or	0 780		

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0 780	Continued From page 9 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in bedrooms #4 and #5 and ensure smoke alarms are interconnected so that the actuation of one alarm causes all alarms in the dwelling to actuate as required. 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 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 residents). The findings include: On March 17, 2022, between 10:00 a.m. and 11:00, survey staff toured the facility with the director of maintenance (DM)-E. During the facility tour, survey staff observed there were no smoke alarms installed in bedroom #4 or bedroom #5. There was no interconnected smoke alarm installed outside bedroom #5. Some of the smoke alarms in the facility were interconnected and some of them were not.	0 780		

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0 780	Continued From page 10 (DM)-E verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. 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) 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 residents). The findings include:	0 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
2 CARING HANDS INC	18712 EUCLID PATH FARMINGTON, MN 55024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 11 On March 17, 2022, from approximately 10:00 a.m. to 11:00 a.m., survey staff toured the facility with the director of maintenance (DM)-E. During the facility tour, survey staff observed the upstairs bathroom floor was missing three tiles, the basement window well was missing the egress ladder, and the designated smoking area did not have a rated ashtray. DM-E verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 12 (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 provide the required fire safety training and evacuation plans for residents and staff. This has 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 the potential to affect a large portion or all residents). The findings include: During the interview on March 17, 2022, at 11:00 a.m., the director of maintenance (DM)-E stated they had not done any training for residents on the updated fire safety plans and did not have a training plan established.	0 810		

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0 810	Continued From page 13 A review of the Fire Safety Program for the Workplace showed the following: 1. No evacuation plan or documentation on specific procedures for the residents including procedures for their movements, and relocation during a fire or similar, and no written instructions for addressing any unique situation during an evacuation, especially for residents who are wheelchair-bound and need assistance during an evacuation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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	01530		

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01530	Continued From page 14 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct care staff received the required amount of dementia care training in the required time frame for two of two employees (unlicensed personnel (ULP)-B and ULP-C) with records reviewed. 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 and ULP-C had start dates of June 1, 2021, and November 20, 2021, respectively. Both records lacked documentation of the required eight hours of annual dementia care training within 160 working hours of employment. On March 16, 2022, at 11:50 a.m. the owner (O)-A stated she was not aware eight hours of dementia training was required by 160 hours of employment, and verified she did not know the	01530		

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01530	Continued From page 15 dementia training guidelines. The undated 2 Caring Hands Inc/Dementia Care Training Policy identified direct care employees must have completed at least eight hours of initial training required topics in the 160 hours from employment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included signatures or other authentication by the residents and agreement on the services to be provided for one of one resident (R1) with record reviewed. 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: R1 was admitted with diagnoses to include morbid obesity. R1 required assistance with personal care reminders, meals, and medication administration. R1's service plan dated May 7, 2021, was not signed by R1 or representative of R1. On March 16, 2022, at 1:00 p.m. owner (O)-A confirmed R1's service plan lacked a signature of R1 or representative. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		

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01650	Continued From page 17	01650		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure service plans included fees for services and a contingency plan for one of one resident (R1) with record reviewed. This practice resulted in a level two violation (a	01650		

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01650	Continued From page 18 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: R1 was admitted to the facility on May 3, 2021. R1's diagnoses included morbid obesity. R1 required assistance with personal care, meals, and medication administration. R1's service plan dated May 7, 2021, lacked fees for services, and a contingency plan which included: -the action to be taken if the scheduled service could not be provided; -information and a method to contact the facility; -the names and contact information of persons the resident wished to have notified in an emergency or if there was a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and -the circumstances in which emergency medical services were not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.. On March 16, 2022, at 1:00 p.m. owner (O)-A confirmed R1's service plan lacked fees for services and a complete contigency plan. No further information was provided. TIME PERIOD FOR CORRECTION:	01650		

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01650	Continued From page 19 Twenty-One (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.	01730		

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01730	Continued From page 20 (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1) with record reviewed. 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: R1's diagnoses included morbid obesity. R1's Service plan, dated May 7, 2021, indicated R1 received medication management services. R1's prescriber orders dated November 10, 2021, included a diuretic, anti-depressants, blood thinners, and blood pressure medication. A policy and procedure regarding medication management was requested, but not provided. R1 lacked a medication management plan to include required content noted below:	01730		

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01730	Continued From page 21 - a statement describing the medication management services that was provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring medication refills were ordered on a timely basis; -identification of medication management tasks delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arose with medication management services; and -any resident-specific requirements relating to documenting medication administration, verifications all medications were administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On March 16, 2022, at approximately 1:00 p.m. owner (O)-A confirmed R1 lacked evidence of a medication management plan to include the above noted content, and O-A was not aware of the requirement for a medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 22 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 standards, medical or nursing standards for three of three residents (R1, R2, R3) who utilized bed rails with records reviewed. This resulted in issuance of an immediate correction order on March 15, 2022, at 1:00 p.m. 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 potential to affect a large portion or all of the residents). The findings include: R1 was admitted with diagnoses including morbid obesity. R2 was admitted with diagnoses including traumatic brain injury. R3 was admitted with diagnoses including dementia. On March 15, 2022, at approximately 12:00 p.m. owner (O)-A verified R1, R2, and R3 had bed rails on their beds. On March 15, 2022, at approximately 1:00 p.m. bilateral half bedrails were observed at the head of R1, R2 and R3's beds. All rails were observed	02310		

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02310	Continued From page 23	02310		

in the raised position. In addition, R2's bedrail was loose on one side of the bed. O-A verified the bedrails had not been assessed for safety, nor was education provided to the resident/resident representative on the risks associated with bed rail use.

A review of 2 Caring Hands Inc Bed Rail Assessment and Resident Consent, dated march 16, 2022, verified R1,R2, and R3's bedrails were measured and assessed in accordance with the food and Drug Administration guideline

The Food and Drug Administration (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."

A review of 2 Caring Hands Inc Bed Rail Assessment and Resident Consent, dated March 16, 2022, verified R1, R2, and R3's bedrails were measured and assessed to be in accordance with FDA guidelines, revised date April 2010.

The licensee's undated Use of Side Rails policy indicated an assessment would be completed and the assessment would determine whether the equipment met the Food and Drug Administration standards for siderails.

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02310	Continued From page 24 No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of correction order, tag identification 2310 was removed March 16, 2022, scope and level of noncompliance remained the same.	02310		

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL31747015 On March 15, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following immediate correction order was issued. At the time of the survey, there were six (6) residents receiving services under the provider's Assisted Living license. On March 15, 2022, an immediate correction order was issued at 2310.	0 000		
02310 SS=I	144G.91 Subd. 4 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	02310		

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02310	Continued From page 1	02310		

by:
Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for three of three residents (R1, R2, R3) who utilized bed rails with records reviewed.

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 potential to affect a large portion or all of the residents).

The findings include:

On March 15, 2022, at approximately 12:00 p.m., owner (O)-A confirmed with surveyors that R1, R2, and R3 had bed rails placed on their beds. The bed rails had not been assessed for safety.

R1 admitted May 3, 2021, with diagnoses including morbid obesity.

R2 admitted April 21, 2020, with diagnoses including traumatic brain injury.

R3 admitted February 7, 2022, with diagnoses including dementia.

On March 15, 2022, at approximately 1:00 p.m.,the surveyor observed half bedrails bilaterally to the beds of R1, R2, R3. R2's bedrail was loose on one side of the bed. O-A acknowledged the residents' records did not contain functional ability assessments indicating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31747	A. BUILDING: _____ B. WING _____	03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
2 CARING HANDS INC	**18712 EUCLID PATH FARMINGTON, MN 55024**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 2 the presence of bedrails, documentation of bedrail education of risks, or consent for the use of bedrails. The licensee's undated Use of Side Rails policy indicated an assessment would be completed and the assessment will determine whether the equipment meets the Food and Drug Administration standards for siderails. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/16/22*
Time: 11:15:20
Report: 1024221048

Food and Beverage Establishment Inspection Report

Location:
2 Caring Hands Inc
18712 Euclid Path
Farmington, MN55024
Dakota County, 19

Establishment Info:
ID #: 0038859
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513448627
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.

OBSERVED TRAY OF CHEESY POTATOES ON COUNTER MEASURING AT 69 dF. PER CARETAKER ITEM LEFT OUT WHILE SHE WAS PORTIONING IT AND WARMING IT UP FOR RESIDENTS. ADVISED TO PLACE FOOD ITEMS IN COOLER WHEN NOT ACTIVELY PORTIONING FOOD ITEMS. ITEM PLACED ON TPHC.

Comply By: 03/16/22

4-500 Equipment Maintenance and Operation

4-501.114A ***** Priority 1 *****

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

OBSERVED SCENTED SANITIZER WIPES. ADVISED TO USE NON SCENTED CHLORINE OR QUATERNARY AMMONIUM FOR SANITIZING.

Comply By: 03/16/22

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.

OBSERVED MULTIPLE FOOD ITEMS IN COOLER SUCH AS DELI MEATS, SOFT CHEESES WITH NO DATE MARKING. ADVISED TO LABEL ITEMS WITH DATE IT WAS OPEN.

Comply By: 03/16/22

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO SMALL DIAMETER PROBE THERMOMETER ON SITE TO MEASURE THINLY SLICED FOOD ITEMS SUCH AS DELI MEATS.

Comply By: 03/16/22

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO IRREVERSIBLE THERMOMETER OR TEMPERATURE TEST STRIPS AVAILABLE ON SITE TO TEST UTENSIL SURFACE TEMPERATURE OF DISHWASHING MACHINE. PROVIDE AND MAINTAIN.

Comply By: 03/16/22

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 TEST CHLORINE LEVELS OF CHLORINE WIPES. PROVIDE AND MAINTAIN.

Comply By: 03/16/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT HAS APPROVED FOOD SAFETY COURSE CERTIFICATE, HOWEVER NO CFPM CERTIFICATE ON SITE. WILL SEND FACT SHEET TO OPERATOR.

Comply By: 03/16/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETER OBSERVED INSIDE COOLER. PROVIDE AND MAINTAIN.

Comply By: 03/16/22

Surface and Equipment Sanitizers

Chlorine: = 200+PPM at Degrees Fahrenheit
Location: SCENTED CLOROX WIPE
Violation Issued: Yes

Utensil Surface Temp: = at 160 Degrees Fahrenheit
Location: DISHWASHING MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/ROAST BEEF
Temperature: 30 Degrees Fahrenheit - Location: MAYTAG COOLER
Violation Issued: No

Process/Item: Cold Holding/CHEESY POTATO
Temperature: 69 Degrees Fahrenheit - Location: COUNTER - PLACED ON TPHC TO BE DISCARDED IN 2 HOURS
Violation Issued: Yes

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	4	2

DISCUSSED ALL ORDERS ON SITE WITH NURSING EVALUATOR ROBYN WOOLLEY AND OPERATORS MOOTOO MURGASEN AND ANN MURGASEN IN ADDITION TO THE FOLLOWING:

- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- REPORTABLE DISEASES.
- HANDWASHING POLICY AND REVIEW.
- VOMIT AND FECAL MATTER CLEAN UP PROCEDURES.
- CFPM.
- THERMOMETER USE.
- THERMOMETER CALIBRATION AND FREQUENCY.
- DATE MARKING AND DISCARD DATE.
- PROPER STACKING ORDER TO AVOID CROSS CONTAMINATION.
- PROPER TEMPERATURES FOR HOT AND COLD HOLDING, REHEATING, AND COOLING.
- PASTEURIZED EGGS: ESTABLISHMENT ONLY COOKS SCRAMBLED EGGS FOR RESIDENTS.
- ESTABLISHMENT ONLY DOES SAME-DAY SERVICE.
- ESTABLISHMENT HAS INTACT POPCORN CEILING, HOLLOW BASE KICK BOARDS AND SMOOTH AND EASILY CLEANABLE FLOORS. CONTINUE TO MONITOR FOR ANY SIGNS OF DAMAGE.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1024221048 of 03/16/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____

MOOTOO MURGASEN
OPERATOR

Signed: 

Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us