Electronically Delivered

August 12, 2024

Licensee
Watchful Caregivers LLC
3806 57th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL35021015

Dear Licensee:

On July 10, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 26, 2024, 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

HHH

Electronically Delivered

May 28, 2024

Licensee
Watchful Caregivers LLC
3806 57th Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL35021015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 26, 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 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment- $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.

OR In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

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.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35021	A. BUILDING: _____ B. WING _____	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATCHFUL CAREGIVERS LLC	3806 57TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(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****** ASSSITED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.01 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: Project # SL35021015 On April 23, 2024, through April 26, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three (3) residents receiving services under the provider's Assisted Living License. An immediate correction order was identified on April 23, 2024, issued for SL35021015, tag identification 0820. On April 24, 2024, the immediacy of order 0820 was removed, however noncompliance remains. 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.	
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide	0 490		

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0 490	Continued From page 1 direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all three residents of the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).	0 490		

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0 490	Continued From page 2 The findings include: On April 23, 2024, at 11:00 a.m., during a tour of the licensee, the surveyor did not observe a posted activity calendar throughout the common areas. During observations on April 23, 24, and 25, 2024, revealed no activities were offered. During the observations, some residents remained in their room all day and some sat in the living room watching television. On April 24, 2024, at 1:20 p.m., R1, R2, and R3 confirmed there were no activities offered. On April 25, 2024, at 2:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated an activity calendar was not posted in a common area or given to residents of the facility. LALD/RN-A stated they provided internet, television, and shopping trips; however they were not aware of the required activities program with the required contents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that	0 580		

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0 580	Continued From page 3 have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activities. This had the potential to affect all three (3) 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: On April 23, 2024, at 10:45 a.m., during the entrance conference, the licensee's quality management documentation was requested for review of any quality management activity. On April 25, 2024, at 2:00 p.m., licensed assisted living director/registered nurse (LALD/RN)-A and administrator (A)-C stated they had a meeting and discussed "many things" regarding quality, however there was no current, formal plan. LALD/RN-A acknowledged the licensee lacked	0 580		

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0 580	Continued From page 4 documentation of quality management meetings or activities. The licensee's Quality Management Program policy, undated, indicated "This Facility shall develop a continuous quality management program to identify, support and maintain the facility's quality improvement efforts and provide quality services to our residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety when the licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living and a posting of	0 640		

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0 640	Continued From page 5 the contact information or reporting number for the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 April 23, 2024, during the facility tour at approximately 11:00 a.m., the surveyors observed common areas; there was no required posting of the 911 emergency number and the reporting number for MAARC. On April 25, 2024, at 2:00 p.m., administrator (A)-C acknowledged the 911 emergency number and the reporting number for MAARC were not posted in common areas. A-C stated she did not think the posting was needed; however, the information was provided to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 6 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all of the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all residents receiving services under the assisted living license, 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	0 680		

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0 680	Continued From page 7 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: During the entrance conference on April 23, 2024, at 10:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-A and administrator (A)-C stated the licensee had an emergency preparedness binder but it was not available onsite. On April 23, 2024, during the facility tour at approximately 11:00 a.m., there was no observed signage posted or information regarding the licensee's emergency plan. On April 24, 2024, at 12:00 p.m., A-C provided an undated Emergency Preparedness manual and A-C confirmed the licensee lacked a customized emergency preparedness plan reviewed/updated annually which included the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility)	0 680		

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0 680	Continued From page 8 - shelter in place; - a tracking system used to document locations or residents and staff - the medical record documentation system to preserve resident information - emergency staff strategies - the facilities role in providing care and treatment at alternative sites - a communication plan that included: - arrangement with other facilities - names and contact information for staff, resident physicians, other facilities management agencies - a method of sharing information and medical documentation for residents - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy -a method of sharing information from the emergency plan with residents and their families - EP training and testing program - EP training program for staff (including documentation of training provided) - EP testing/annual testing requirements On April 25, 2024, at 2:00 p.m., A-C confirmed staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). A-C also verified the licensee had not fully developed and implemented the facility's emergency preparedness plan/program. The licensee Emergency Preparedness policy dated August 01, 2021, indicated the license would implement an emergency management program.	0 680		

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0 680	Continued From page 9 No further 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 sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms on each story of the dwelling and failed to provide interconnected	0 780		

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0 780	Continued From page 10 smoke alarms so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. 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 of the residents). Findings include: On a facility tour on April 23, 2024, at 12:00 p.m., with administrator (A)-C, and registered nurse (RN)-A it was observed that smoke alarms inside, and outside of and in the immediate vicinity of main floor resident rooms 1, 2, 3, and 4 were not interconnected, and that there was no smoke alarm present in the basement level. During the tour, A-C and RN-A, verified the findings and stated they understood the deficiencies and would replace the main floor detectors and install a detector in the basement that are all interconnected. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire	0 790		

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	35021	A. BUILDING: _____ B. WING _____	04/26/2024

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WATCHFUL CAREGIVERS LLC	3806 57TH AVENUE NORTH BROOKLYN CENTER, MN 55429

(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
0 790	Continued From page 11 extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers in accordance with MN Statute. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety 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). On a facility tour, on April 23, 2024, at 12:00 p.m., with administrator (A)-C, and registered nurse (RN)-A, it was observed that records were not available to show the main floor fire extinguisher had received annual testing or monthly inspections. The fire extinguisher in the basement level was not mounted and did not have record of annual testing or monthly inspections. Survey staff explained to A-C, and RN-A, that the	0 790		

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0 790	Continued From page 12 portable fire extinguishers are required to be provided annual certification tags, and monthly visual inspection (quick checks) by a staff member. The visual inspection is required to ensure all extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition that would prevent their operation when needed. Survey staff explained that portable fire extinguishers are required to be mounted in locations so that the travel distance to nearest extinguisher does not exceed 75 feet. During the tour, A-C, and RN-A, verified the findings and stated that they understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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	0 800		

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0 800	Continued From page 13 failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on April 23, 2024, at 12:00 p.m., with administrator (A)-C, and registered nurse (RN)-A it was observed the following: Resident room 1 had damage to the wall around the electrical outlets and broken trim on the side door jamb. Resident room 2 door would not latch, the doorknob was loose and not working properly, and the outlet covers were missing from two electrical outlets. Resident room 3 had damage to the wall around the electrical outlets. The main floor bathroom was not provided with an exhaust fan. There was rust on the metal parts of the window and the metal air vent. There was broken trim on the side door jamb.	0 800		

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0 800	Continued From page 14 The kitchen widow had broken glass on the interior windowpane. The carbon monoxide detector outside of main floor resident rooms was not working. The man door from the garage to the exterior was blocked with boxes and the man door from the garage to the dwelling had a keyed lock that operated with a thumb turn from the dwelling side of the door. There was no approved, unobstructed exit from the inside of the garage. All interior spaces are required to be provided with approved exits to be used in the event of a fire or similar emergency. The clothes dryer vent in the basement had a broken elbow. Dryer heat and exhaust was discharging into the dwelling. The ceiling light fixture above the clothes washer in the basement was loose and partially hanging from the wires. There was an extension cord plugged into a ceiling outlet in the basement laundry room that extended through a wall where it was cut off, exposing energized wires. There was tape on the main electric panel in the basement covering blank spaces in the panel missing circuit breakers. There was an electrical outlet in the far-left corner away from the stairs in the basement that was not mounted in the box, it was loose, and the sides of the outlet were exposed. There was an electrical outlet on the long wall	0 800		

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0 800	Continued From page 15 opposite the laundry room in the basement that was missing the cover plate. There were two refrigerators plugged into the same extension cord with no overcurrent protection in the basement laundry room. During the tour, A-C, and RN-A, verified these deficient findings at the time of discovery. It was also stated by A-C, and RN-A, that they recently purchased the facility and a number of the deficient items discovered were known and that they are working to get them fixed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 16 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 and 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 or has potential to affect a large portion or all of the residents). The findings include: On April 23, 2024, administrator (A)-C, and registered nurse (RN)-A, provided documents on the fire safety and evacuation plan (FSEP), fire	0 810		

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0 810	Continued From page 17 safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled Emergency Preparedness 1.17 Fire Safety Handout, undated, failed to provide the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with manual fire alarms. The policies had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at this licensed facility which did not have manual fire alarms. The plan did it include procedures for staff to follow in case of relocation of residents. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include unique needs/evacuation status for each individual resident in writing and readily available for use in the event of a fire or similar emergency.	0 810		

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0 810	Continued From page 18 During an interview on April 23, 2024, at 1:30 p.m., A-C, and RN-A, stated they understood the areas of the policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to residents, at least once per year as evident by not providing documentation of training offered or training scheduled for a future date. Record review indicated the licensee failed to provide evacuation training based on the fire safety and evacuation plan to employees, at hire and twice per year as evident by not providing documentation of training offered or training scheduled for a future date. During an interview on April 23, 2024, at 1:30 p.m., A-C, and RN-A, confirmed that residents had not received training on the fire safety and evacuation plan. A-C and RN-A stated that employee records were not kept on site and that training records for facility staff would be emailed to the surveyor. No further documentation was provided. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by not providing documentation showing any evacuation drills had been conducted.	0 810		

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0 810	Continued From page 19 During an interview on April 23, 2024, at 1:30 p.m., A-C and RN-A stated that records were not available for evacuation drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=I	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 failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all of the residents and staff. 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	0 820		

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0 820	Continued From page 20 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 a facility tour on April 23, 2024, at 12:00 p.m., with administrator (A)-C, and registered nurse (RN)-A it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms 1, 2, 3, and 4. OCCUPIED RESIDENT ROOMS Resident sleeping room 1, occupied by R1, emergency escape and rescue clear window opening measurements are 35 inches wide, 12 1/2 inches in height and 438 square inches in openable area. The window was measured with A-C, RN-A, and survey staff present. The window did not meet the minimum requirements for clear opening height and area. Resident sleeping room 3, occupied by R3, emergency escape and rescue clear window opening measurements are 30 1/2 inches wide, 14 inches in height and 427 square inches in openable area. The window was measured with A-C, RN-A, and survey staff present. The window did not meet the minimum requirements for clear opening height and area. Resident sleeping room 4, occupied by R2, emergency escape and rescue clear window opening measurements are 39 inches wide, 10 1/2 inches in height and 410 square inches in openable area. The window was measured with A-C, RN-A, and survey staff present. The window did not meet the minimum requirements for clear	0 820		

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0 820	Continued From page 21 opening height and area. UNOCCUPIED ROOM Resident sleeping room 2, unoccupied, emergency escape and rescue clear window opening measurements are 35 inches wide, 12 1/2 inches in height and 438 square inches in openable area. The window was measured with A-C, RN-A, and survey staff present. The window did not meet the minimum requirements for clear opening height and area. It was explained to A-C and RN-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. These deficient conditions were visually verified by A-C and RN-A, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On April 24, 2024, the immediacy of order 0820 was removed, however noncompliance remains. The scope and level remain unchanged.	0 820		

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01290	Continued From page 22	01290		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the licensee's health facility identification number (HFID) prior to providing services to residents for one of two employees (registered nurse (RN)-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, 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:	01290		

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01290	Continued From page 23 RN-B had a hire date of June 15, 2023, to provide direct care services to the licensee's residents. RN-B's employee record lacked documentation of a valid registered nurse license in the State of Minnesota. RN-B's employee record contained a background study dated June 15, 2023, affiliated to licensee's comprehensive home care HFID 98392. RN-B's employee record lacked evidence the licensee affiliated a background study for RN-B under the current assisted living facility HFID. On April 25, 2024, at 2:00 p.m., administrator (A)-C stated they are aware of the requirement for the licensee to affiliate a background study for all staff under the current HFID. However, RN-B was hired to provide services to their comprehensive license and recently started helping the assisted living facility because they were short of staff. A-C acknowledged the licensee missed affiliating a background study for RN-B under the current HFID. The licensee's Background Studies policy, undated, indicated the licensee required background screening to be completed on all employees, contractors, and regularly scheduled volunteers. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01310 SS=F	144G.60 Subd. 3 Licensed health professionals and nurses	01310		

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01310	Continued From page 24 (a) Licensed health professionals and nurses providing services as employees of a licensed facility must possess a current Minnesota license or registration to practice. (b) Licensed health professionals and registered nurses must be competent in assessing resident needs, planning appropriate services to meet resident needs, implementing services, and supervising staff if assigned. (c) Nothing in this section limits or expands the rights of nurses or licensed health professionals to provide services within the scope of their licenses or registrations, as provided by law. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure a registered nurse (RN), who was providing services as an employee of the licensed facility, had a current Minnesota license or registration to practice, for one of two employees (RN-B), which had the potential to affect all 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). The findings include: During the entrance conference on April 23, 2024, at 10:45 a.m., licensed assisted living director/registered nurse (LALD/RN)-A and administrator (A)-C provided the licensee's employee list. The licensee's Employee List form	01310		

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01310	Continued From page 25 dated April 22, 2024, indicated RN-B was a RN and was hired June 15, 2023. Also, RN-A stated personal care assistance (PCA) don't provide any cares or medication administrations to residents. Only Nurses provide medication administration and cares. On April 25, 2024, at 2:00 p.m. A-C stated RN-B was hired to provide services to their comprehensive license and recently started helping the assisted living facility because they were short of staff. During record review on May 9, 2024, at 2:00 p.m., the Minnesota (MN) Board of Nursing online licensure verification system indicated RN-B did not have a valid RN license. On May 10, 2024, at 1:23 p.m., A-C indicated via email "We went to retrieve records from the facility. RN-B is a student nurse scheduled for the state board in the near future. She does not have the RN license but was hired as a student nurse." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01310		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of	01500		

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	35021	A. BUILDING: _____ B. WING _____	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01500	Continued From page 26 vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased	01500		

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	35021	A. BUILDING: _____ B. WING _____	04/26/2024

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01500	Continued From page 27 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received annual training for each 12 months of employment in the required topics for one of two employees (registered nurse (RN)-A). 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: RN-A was hired July 23, 2021, and provided direct cares for the residents of the facility. RN-A's employee record included annual training completed July 21,2023, however RN-A's records lacked evidence RN-A had successfully completed annual training in the following areas: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of the facility's policies and procedures;	01500		

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01500	Continued From page 28 and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On April 25, 2024, at 2:00 p.m., administrator (A)-C stated RN-A completed annual training, but A-C verified RN-A's record lacked evidence that required topics of annual training had been successfully completed. The licensee's Qualification, Training, and Competency policy, undated, indicated the licensee provided training to all staff providing and supervising assisted living services at the time of hire, and as needed to meet state guidelines and quality standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
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 and the Office of Ombudsman	01640		

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01640	Continued From page 29 for Mental Health and Developmental Disabilities. (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's representative to document agreement on the services to be provided for one of two residents (R2). 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: R2 was admitted to licensee on December 1, 2022. R2's record lacked a current service plan with signature or authentication by the resident or resident's representative with all current services provide by licensee. R2's Service Plan with effective and print date of	01640		

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01640	Continued From page 30 April 24, 2024, included the services of activities of daily living, blood pressure check, tube feeding, and medication administration. On April 25, 2024, at 2:30 p.m., during interview, licensed assisted living director/registered nurse (LALD/RN)-A acknowledged R2's record lacked a current signed and authenticated service plan. LALD/RN-A stated it is the licensee's practice to have all service plans signed. LALD/RN-A also stated they misplaced the signed service plan and printed an unsigned service plan for the surveyor to review. The licensee's Service Plan policy undated, indicated the service plan and any revisions must include a signature or other authentication by the assisted living provider and by the resident's representative documenting agreement on the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by:	03090		

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03090	Continued From page 31 Based on observation, interview, and record review, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect residents, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 23, 2024, at 10:00 a.m., surveyors entered the facility and at the main entry there was no signage to notify visitors of electronic monitoring. During a tour of the facility at 11:15 a.m., administrator (A)-C stated "we don't have any monitoring." A-C verified there was no posted signage regarding the potential for electronic monitoring. The licensee's Electronic Monitoring policy dated January 1, 2020, indicated the licensee complies with the Minnesota Electronic Monitoring law. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health

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

Type: Full
Date: *04/26/24*
Time: 11:50:58
Report: 1051241007

Food and Beverage Establishment Inspection Report

Location:
Watchful Caregivers Llc
3806 57th Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038924
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7635354326
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

THIS FACILITY WAS INSPECTED BY KAI YANG (MDH).

DID NOT MEET WITH NURSE SURVEYOR, SAFIA HASSAN.

MET WITH FACILITY NURSES: MARTHA AND NANNIE AND MANAGER, SOLOMON AKWAKA.

TOPICS DISCUSSED WITH SOLOMON AKWAKA:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
HIGHLY SUSCEPTIBLE POPULATION
SAME-DAY SERVICE

SOLOMON RENEWED HIS CFPM ON 4/5/2024 AND IS WAITING FOR IT TO GET MAILED.

THE KITCHEN HAS A DOMESTIC HIGH TEMP DISHWASHER, POPCORN TEXTURE CEILING, LAMINATE FLOORS AND COUNTERS, AND MDF WOODEN CABINETS. THERE IS AN UPRIGHT COOLER FOR STAFF USE ONLY AND UPRIGHT FREEZER IN THE BASEMENT.

Type: Full
Date: *04/26/24*
Time: 11:50:58
Report: 1051241007
Watchful Caregivers Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1051241007 of 04/26/24.

Certified Food Protection Manager: Solomon Akwaka

Certification Number: FM122418 Expires: 04/05/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Solomon Akwaka

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