Electronically Delivered

May 16, 2025

Licensee
TFF Care LLC
4200 40th Avenue North
Robbinsdale, MN 55422

RE: Project Number(s) SL21574016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 10, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21574	A. BUILDING: _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	4200 40TH AVENUE NORTH ROBBINSDALE, MN 55422

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21574016-0 On April 7, 2025, through April 10, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 159 residents; 74 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 7, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 630 SS=E	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R4, R5). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4 was admitted on December 3, 2021, with diagnoses of history of falls, anxiety, and toxic encephalopathy (brain dysfunction caused by	0 630		

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0 630	Continued From page 4 toxic exposure). R4's Service Plan dated October 22, 2024, indicated R4 received assistance with medication administration. On April 10, 2025, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-A administer medication to R4. R4's IAPP completed on January 27, 2025, lacked assessment of the resident's susceptibility to abuse by other individuals; and statements of the specific measures to be taken to minimize the risk of abuse to the resident. R5 R5 was admitted on September 25, 2024, with diagnoses of high blood pressure, chronic obstructive pulmonary disease (COPD), and diabetes. R5's Service Plan dated February 28, 2025, indicated R5 received assistance with medication administration and blood glucose monitoring. On April 8, 2025, at 11:05 a.m., the surveyor observed ULP-B administer medications to R5. R5's IAPP completed on January 16, 2025, lacked assessment of the resident's susceptibility to abuse by other individuals; and statements of the specific measures to be taken to minimize the risk of abuse to the resident. On April 10, 2025, at 2:15 p.m., the surveyor observed clinical nurse supervisor (CNS)-D reviewing assessments in the electronic medical records and acknowledged the required questions were not assessed by the nurse.	0 630		

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0 630	Continued From page 5 CNS-D stated they could work with their electronic medical record system to make the required questions a requirement to be answered by the nurses. The licensee's Development of the Individualized Abuse Prevention Plan policy dated June 9, 2023, indicated the IAPP would include the resident's susceptibility to be abused by another individual or other vulnerable adult; and specific measures to minimize the risk of abuse to the resident if any risks were identified. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 660		

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0 660	Continued From page 6 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), to include an updated facility TB risk assessment and a two-step tuberculin skin test (TST) or other evidence of TB testing such as IGRA (a blood test) for two of two unlicensed personnel ((ULP)-A, ULP-B). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee's Facility TB Risk Assessment dated April 2022, was completed on May 1, 2024. The assessment identified the national rate was 3.0 percent and the Minnesota rate was 3.4 percent for 2021 (data for 2022 not yet available). The assessment form and data used to complete the incidence of TB was not current information at the time the assessment was completed. On April 7, 2025, at 1:34 p.m., corporate compliance officer/attorney (CCO/A)-I stated they had failed to update the year on the form and would resend the correct data used and said the percentage data was accurate.	0 660		

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0 660	Continued From page 7 On April 7, 2025, at 3:10 p.m., clinical nurse supervisor (CNS)-D provided an updated Facility TB Risk Assessment. The licensee's Facility TB Risk Assessment dated April 2022, was completed on May 1, 2024, identified the national rate was 2.9 percent and the Minnesota rate was 2.8 percent for 2023 (data for 2024 not yet available). The data for the incidence of TB was changed from the previously provided Facility TB Risk Assessment. The TB risk level was indicated to be low. On April 7, 2025, at 3:29 p.m., the surveyor received an email from clinical nurse supervisor (CNS)-D who had forwarded an email from corporate compliance officer/attorney (CCO/A)-I dated April 7, 2025, at 2:09 p.m., indicated they had updated the 2023-2024 TB Risk Assessment. ULP-A ULP-A was hired on March 7, 2012, to provide direct care to residents. ULP-A's personnel record lacked documentation of TB testing that included a two-step TST or IGRA blood test. ULP-B ULP-B was hired on August 6, 2020, to provide direct care to residents. ULP-B's personnel record lacked documentation of TB testing that included a two-step TST or IGRA blood test. On April 10, 2025, at 2:15 p.m., CNS-D stated in the past the licensee did not do TB testing and would only get a chest x-ray. On April 10, 2025, at 2:42 p.m., CCO/A-I stated	0 660		

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0 660	Continued From page 8 they updated the TB Risk Assessment form when the surveyor asked for the data used to complete the form as they only had preliminary data at the time when they completed it. CCO/A-I stated any staff that had a chest x-ray was accepted as permissible documentation. CCO/A-I stated if the licensee needed to go through their personnel files to ensure all staff had a TB test, then they would. CCO/A-I stated they were not aware they needed to correct for all staff and had updated their files for staff hired after 2019 and forward. CCO/A-I stated the licensee now does a two-step TST and if they had a positive TB test, then they would get the chest x-ray. The licensee's TB Prevention and Control policy dated May 25, 2023, indicated at or after time of hire and prior to any contact with residents, employees and all volunteers would be screened for TB symptoms and would be tested for TB. The policy also indicated if there were no documentation of a positive TST or documentation of treatment from the provider to accompany a negative chest x-ray, then the usual testing process would be followed to include a two-step TST preferred method. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses	0 680		

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0 680	Continued From page 9 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 interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 680		

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0 680	Continued From page 10 The licensee's undated EPP lacked evidence of the following required content: - subsistence needs for staff and patients; and - methods for sharing information. On April 9, 2025, at 11:45 a.m., licensed assisted living director (LALD)-C stated the licensee always had enough food on hand for three days, however they did not have any back up water on hand. LALD-C stated the licensee did not have a policy and procedure to address minimum food, water, pharmaceutical supplies, alternate sources of energy, or sewage/waste disposal in the event the licensee had to evacuate or shelter in place for staff and residents. The licensee's Emergency Preparedness Policies and Procedures policy dated October 12, 2022, indicated the purpose of the plan was to establish procedures for the safe and orderly response to an emergency to ensure continuity of operations. The policy did not reference the facility's requirement to also comply with CMS (Centers for Medicare and Medicaid Services) Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor	0 970		

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0 970	Continued From page 11 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language that waived the licensee's liability for the health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On April 7, 2025, at 1:32 p.m., clinical nurse supervisor (CNS)-D provided the licensee's blank assisted living contract and indicated the contract was used for all residents. The licensee's contract dated May 28, 2024, on page 22, indicated the licensee was not responsible for any loss, damage or injury that is done to resident ... or resident's property ... in the apartment or community caused by (including but not limited to): - intentional, negligent or careless acts of residents; - actions in violation of the terms of the resident agreement, resident handbook, and/or providers policies and procedures.	0 970		

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0 970	Continued From page 12 On April 10, 2025, at 2:42 p.m., corporate compliance officer/attorney (CCO/A)-I stated the resident agreement was amended after the licensee's 2023 survey. The language came directly from the MDH website as for what could be included or excluded. The website Assisted Living: Resources and Frequently Asked Questions (FAQs) - MN Dept. of Health accessed on April 29, 2025, at 11:39 a.m., indicated an assisted living contract could not contain any waiver of facility liability with health, safety and personal property of resident and then further clarified there may be many situations such as natural disasters and acts of third parties which would not be the responsibility of the licensee but an assisted living licensee could be liable depending on the licensee's role in the resident's loss and those narrow instances may not be waived. The licensee also provided the surveyor snap shots of the same wording as noted above from the MDH website as well. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
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.	01290		

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	21574	A. BUILDING: _____ B. WING _____	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	4200 40TH AVENUE NORTH ROBBINSDALE, MN 55422

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01290	Continued From page 13 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member 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 observation, interview, and record review, the licensee failed to ensure a background study was affiliated with the licensee's assisted living health facility identification (HFID) number for one of ninety-six employees (licensed practical nurse (LPN)-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 9, 2025, at 11:20 a.m., the surveyor observed licensed assisted living director (LALD)-C log into NETStudy 2.0 (web-based system used to submit background study requests). The surveyor did not observe LPN-H on the licensee's NetStudy 2.0 roster for HFID 21574. LPN-H was hired on September 25, 2017, to	01290		

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01290	Continued From page 14 provide direct care to residents. On April 9, 2025, at 2:35 p.m., the surveyor observed LPN-H in the secured dementia unit. LPN-H stated they had worked for the licensee since 2017 at two different locations in their memory (dementia) care units and on the non-secured dementia units if needed. LPN-H stated they provided residents with cares that included medication administration and performing treatments. LPN-H's Background Study Clearance dated September 24, 2017, indicated the background study was affiliated to a different HFID 20297. On April 9, 2025, at 2:51 p.m., the surveyor received an email from LALD-C indicating LPN-H was affiliated to the licensee's HFID 21574 on April 9, 2025. On April 9, 2025, at 3:25 p.m., LALD-C stated they were not sure what had happened as LPN-H had been separated in 2024 in error. On April 9, 2025, at 4:16 p.m., LALD-C stated they believed the error was to be within NetStudy and was not the licensee's error. The licensee's Screening & Background Studies for Job Applicants policy dated September 30, 2022, indicated all new hires would be screened through DHS (Department of Human Services) background prior to providing services to residents. Also, the policy indicated the licensee shall maintain their NetStudy 2.0 roster up to date. No further information provided.	01290		

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01290	Continued From page 15 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure reassessment and monitoring were completed no more than fourteen calendar days after initiation of services; and ongoing resident reassessment and monitoring were completed as needed based	01620		

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01620	Continued From page 16 on changes in the needs of the resident but not to exceed 90 calendar days from the last date of assessment for two of two residents (R4, R5). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 R4 was admitted on December 3, 2021, with diagnoses of history of falls, anxiety, and toxic encephalopathy (brain dysfunction caused by toxic exposure). R4's Service Plan dated October 22, 2024, indicated R4 received assistance with medication administration. On April 10, 2025, at 8:57 a.m., the surveyor observed unlicensed personnel (ULP)-A administer medication to R4. R4's Comprehensive Assessment dated December 20, 2021, indicated it was a fourteen-day assessment. The assessment was completed 17 days after the initiation of services. R4's record included 90-day nursing assessments dated October 27, 2024, and January 27, 2025. The assessment completed on January 27, 2025, indicated 92 days had passed	01620		

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01620	Continued From page 17 since the prior assessment completed on October 27, 2024. R5 R5 was admitted on September 25, 2024, with diagnoses of high blood pressure, chronic obstructive pulmonary disease (COPD), and diabetes. R5's Service Plan dated February 28, 2025, indicated R5 received assistance with medication administration and blood glucose monitoring. On April 8, 2025, at 11:05 a.m., the surveyor observed ULP-B administer medications to R5. R5's record included a 14-day assessment dated October 10, 2024, and a 90-day nursing assessment dated January 16, 2025. The assessment completed on January 16, 2025, indicated 98 days had passed since the prior assessment completed on October 10, 2024. On April 10, 2025, at 2:15 p.m., clinical nurse supervisor (CNS)-D stated it was the licensee's policy to make every effort to make sure the assessments were done timely. CNS-D stated they used a report to indicate which assessments were due every 90 days however this was an oversight. The licensee's Initial and On-Going Nursing Assessment of Clients policy dated March 14, 2024, indicated a registered nurse (RN) would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs as required up to fourteen days after the start of services; and ongoing assessments would be completed periodically but no less than every 90 days. The policy did not indicate the	01620		

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01620	Continued From page 18 requirement to not to exceed 90 calendar days from the last date of assessment No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of	01910		

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01910	Continued From page 19 medications for one of two discharged residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's Discharge/Transfer Summary dated April 7, 2025, indicated R1 was discharged on January 27, 2025, to nursing home or long-term care due to a higher level of care needed; and medications were destroyed per policy by an RN. R1's Current Medications at Discharge dated April 7, 2025, was identified by clinical nurse supervisor (CNS)-D as R1's medication disposition, lacked documentation of the prescription numbers, quantity, to whom the medications were given, date of disposition, and the names of staff and other individuals involved in the disposition. On April 8, 2025, at 10:47 a.m., CNS-D stated the medications were never counted for the medication disposition at discharge. CNS-D stated the licensee's process was to release medications back to the resident anytime the licensee was to stop medication management for a resident. CNS-D stated they thought it was a misunderstanding with their nurses and would provide more education to all the nurses.	01910		

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01910	Continued From page 20 The licensee's Disposition or Disposal of Medication policy dated April 10, 2025, indicated medications that were secured or stored by the facility would be given to the resident or the residents representative when the resident's medication management services were terminated. Also, the policy indicated documentation of the disposition of medications would include documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident's record for two years. The policy failed to include all the requirements for documentation of a medication disposition and only included documentation for medication destruction. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01910		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs.	01960		

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01960	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately transcribe provider orders for one of one resident (R5) who had a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 9, 2025, at 12:20 p.m., the surveyor observed unlicensed personnel (ULP)-F administer insulin to R5. During the observation, R5 stated they had already eaten lunch, and R5's power of attorney stated they met R5 in the room at 11:30 a.m. after R5 had eaten lunch. R5 was admitted on September 25, 2024, with diagnoses of high blood pressure, chronic obstructive pulmonary disease (COPD), and diabetes. R5's Service Plan dated February 28, 2025, indicated R5 received assistance with medication administration and blood glucose monitoring. R5's physician telephone order dated September 26, 2024, indicated to check blood glucose before meals and insulin four times per day.	01960		

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01960	Continued From page 22 R5's Treatment Recap Summary - Monthly (treatment administration record (TAR)) dated April 2025, indicated blood glucose monitoring was scheduled at 8:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. R5's TAR did not indicate to check blood glucose before meals and insulin. On April 9, 2025, at 12:51 p.m., registered nurse (RN)-G stated usually blood sugar checks and insulin would be given before a meal. RN-G stated R5's blood glucose was scheduled at mealtime but the ULPs could perform the task an hour before or an hour after the scheduled time. RN-G stated R5's record should have had the blood glucose instructions to be more specific to indicate to perform before a meal since R5's insulin dosage was based on a sliding scale per the blood glucose results. RN-G stated the blood glucose instructions only indicated when to notify the nurse or to offer a snack but did not indicate to check prior to a meal. On April 9, 2025, at 1:07 p.m., ULP-F stated they checked R5's blood glucose just prior to the surveyor's arrival in R5's room and it was completed after R5 had eaten lunch. On April 10, 2025, at 1:39 p.m., RN-G acknowledge R5's blood glucose order was not transcribed as ordered and stated they would update the treatment order in the system. On April 10, 2025, at 2:15 p.m., clinical nurse supervisor (CNS)-D stated R5 did not have any blood glucose orders on admission day, so they had to call for the orders. CNS-D stated usually when they got blood glucose orders, they are typically very clear and felt this was an isolated event that the order was not transcribed accurately. CNS-D stated the licensee should	01960		

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01960	Continued From page 23 update their blood glucose instructions for all residents with blood glucose monitoring. CNS-D stated the licensee had an annual skills fair coming up and it would be good to add to the blood glucose training for all staff. The licensee's Implementation of Medication Prescriptions and Treatment and Therapy Orders policy dated August 1, 2021, indicated upon receipt of an order from an authorized prescriber, the RN or appropriate staff delegated by the RN must take action to implement the order by adding the order to the resident record in the appropriate place and update the service plan, care plan, administration record, individual treatment therapy plan or other documents as necessary to reflect any changes in orders. Also, the policy indicated the RN or LPN must include in the client's record written instructions for staff to follow when implementing the new order. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

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

Type: Full
Date: *04/07/25*
Time: 10:45:00
Report: 1039251111

Food and Beverage Establishment Inspection Report

Location:
Tff Care Llc
4200 40th Avenue North
Robbinsdale, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0039076
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632771001
ID #:

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

The following orders were issued during this inspection.

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

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

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

PACKAGE OF RAW WHOLE MEAT STORED ON TOP OF BOX OF CANTALOUPE IN WALK-IN-COOLER. RAW MEAT MOVED TO RACK WITH OTHER RAW MEATS, CORRECTED ON SITE.

Corrected on Site

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

3-302.11A(2) ***** Priority 1 *****

MN Rule 4626.0235A(2) Separate types of raw animal foods from other raw animal foods during storage, preparation and display based on cook temperature.

RAW GROUND MEAT STORED ABOVE WHOLE RIBS IN WALK-IN COOLER. STACKING ORDER CORRECTED ON SITE.

Corrected on Site

4-700 Sanitizing Equipment and Utensils

4-703.11C ***** Priority 1 *****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

CHLORINE RESIDUAL ON IN-USE DISHWASHING MACHINE IN MAIN KITCHEN MEASURES 0 PPM. STAFF WILL USE 3-COMP WITH QUAT. SANITIZER UNTIL DISHWASHING MACHINE IS DELIVERING 50-200 PPM CHLORINE RESIDUAL.

Comply By: 04/07/25

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

BACK OF KITCHEN HANDWASHING SINK IS BLOCKED, HANDWASHING SINKS IN 2 MEMORY CARE REMOTE SERVICE AREAS ARE BLOCKED OR DISUSED. MAINTAIN ALL THESE HANDWASHING SINKS AVAILABLE FOR HANDWASHING ONLY (SOAP, PAPER TOWEL, REMINDER SIGN).

Comply By: 04/07/25

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

CAULK SEAL TO WALL FOR 3-COMP SINK, DRAIN BOARD AT DIRTY SIDE OF DISH MACHINE ARE IN BAD REPAIR OR MISSING. RESEAL TO WALL.

Comply By: 05/05/25

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

EXHAUST HOOD OVER GRILL IS NOT DRAWING AIR. PERSON-IN-CHARGE SUSPECTS THE DRIVE BELT FOR FAN IS BROKEN. REPAIR TO MAKE EXHAUST SYSTEM FUNCTION.

Comply By: 04/14/25

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

SOIL OBSERVED ON BAFFLE INSIDE ICE MACHINE. DISCARD ICE, THEN CLEAN/SANITIZE ICE CONTACT SURFACES, COMPLY WITH PART 4. ABOVE.

Comply By: 04/07/25

Surface and Equipment Sanitizers

Quaternary Ammonium: = 300 PPM at Degrees Fahrenheit
Location: KITCHEN WIPING CLOTH BUCKET
Violation Issued: No

Quaternary Ammonium: = 300 PPM at Degrees Fahrenheit
Location: LODGE REMOTE KITCHEN WIPING CLOTH BUCKET
Violation Issued: No

Quaternary Ammonium: = 300 PPM at Degrees Fahrenheit
Location: KITCHEN 3-COMP SINK
Violation Issued: No

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: UNDER-COUNTER DISH MACHINE IN LODGE REMOTE KITCHEN
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BAGGED CHEESE
Temperature: 40 Degrees Fahrenheit - Location: COLD HOLD, WALK-IN COOLER
Violation Issued: No

Process/Item: COOKED CARROT
Temperature: 40 Degrees Fahrenheit - Location: COLD HOLD, WALK-IN COOLER
Violation Issued: No

Process/Item: TURKEY BURGER
Temperature: 167 Degrees Fahrenheit - Location: HOT HOLD, KITCHEN STEAM WARMER
Violation Issued: No

Process/Item: SOUR CREAM
Temperature: 38 Degrees Fahrenheit - Location: COLD HOLD, COOLER IN MANOR MEMORY CARE

Violation Issued: No

Process/Item: TURKEY BURGER
Temperature: 158 Degrees Fahrenheit - Location: HOT HOLD, STEAM WARMER IN MANOR MEMORY CARE
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COLD HOLD, COOLER IN LODGE MEMORY CARE

Violation Issued: No

Process/Item: TURKEY BURGER
Temperature: 137 Degrees Fahrenheit - Location: HOT HOLD, STEAM WARMER IN LODGE REMOTE KITCHEN
Violation Issued: No

Type: Full
Date: *04/07/25*
Time: 10:45:00
Report: 1039251111
Tff Care Llc

Food and Beverage Establishment Inspection Report

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

Establishment main kitchen and remote kitchen have commercial food service equipment and facilities.

2 remote service areas are in memory care wards. These spaces serve food delivered from main kitchen. These areas have a mix of commercial and non-commercial equipment and finish. As noted in orders, all food service areas must have convenient handwashing available.

Inspection results review with MDH nurse evaluator Rhawnie Quinehan.

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 1039251111 of 04/07/25.

Certified Food Protection Manager: Thomas Randle

Certification Number: CFPM-2929
8 Expires: 01/08/28

Inspection report reviewed with person in charge and emailed.

Signed: _____
Thomas Randle
person-in-charge

Signed: _____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us

Food Establishment Inspection Report

Report #: 1039251111

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	3
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 04/07/25
Time In 10:45:00
Time Out

Tff Care Llc	**Address** 4200 40th Avenue North	**City/State** Robbinsdale, MN	**Zip Code** 55422	**Telephone** 7632771001
License/Permit # 0039076	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT (N/O)	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN (OUT)	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN (OUT) N/A N/O	Food separated and protected	X	
16	IN (OUT) N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	(IN) OUT N/A N/O	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	(IN) OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A (N/O)	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 04/07/25

Inspector (Signature)